

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 28 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

13839

1. PLACE OF DEATH

County Stoddard
Township 210
City Lavalle (No. _____ St. _____ Ward _____)

Registration District No. 836
Primary Registration District No. 6100

File No. 10
Registered No. 10

2. FULL NAME

Clarence Albert Boyd

(a) Residence, No. _____ St. _____ Ward _____ (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-16-36
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 2 14
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. Stoddard Co
13. NAME Chas. C. Boyd
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
15. MAIDEN NAME Hola Taylor
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT Chas. C. Boyd, Lavalle
18. BURIAL, CREMATION, OR REMOVAL PLACE Barber Cemetery 3/4 1937
19. UNDERTAKER (ADDRESS) John H. Hines, Liberty
20. FILED 3/4 1937 F. Lawrence Dean Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/2, 1937

22. I HEREBY CERTIFY, That I attended deceased from 2-18, 1937, to 3/2, 1937.
I last saw him alive on 2-18, 1937. Death is said to have occurred on the date stated above, at 5 A. M.

The principal cause of death and related causes of importance were as follows:

Bronchial Pneumonia

Other contributory causes of importance: 107a

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 3/2, 1937.
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____ (Signed) W. S. Davis, M. D.
(Address) Depta

107a

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH
 County Stoddard Registration District No. 836
 Township Elm Primary Registration District No. 6100
 City (No.) St. Ward

File No. 13839
 Registered No. _____

2. FULL NAME Clarence Albert Boyt
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 2 14

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 19 1937 Florence Allen Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/2, 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

bronchial pneumonia Date of onset _____

Other contributory causes of importance:

No measles or whooping cough.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____ (Signed) S. S. Davis M. D.

(Address) Dexter

SUPPLEMENT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

5-13937