

OCT 14 1937

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

33052
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1008**
(c) City **St. Louis** (d) Street No. **BARNES HOSPITAL** Registered No. **9106**
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

(a) Residence, No. **Baby Boyd**
1515 1/2 N. Taylor St. **11**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Colored** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **8-2-37**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
Stillborn **12-Weeks**

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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) **St. Louis, MO**

13. NAME **John T. Boyd**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Miss 1551/2 p1**

15. MAIDEN NAME **Mable Lee Anderson**

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

17. INFORMANT (ADDRESS) **John T. Boyd**
1515 1/2 N. Taylor

18. BURIAL, CREMATION, OR REMOVAL PLACE **Anatomical Board** **92** **37**

19. FUNERAL DIRECTOR (ADDRESS) **BARNES HOSP**
630 N. Kingshighway

20. FILE **SEP 29 1937** **J. T. Brebeck**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **8-2-37**

22. I HEREBY CERTIFY, That I attended deceased from **8-2-37**, 19....., to....., 19.....
I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at **9:20 P.M.**
The principal cause of death and related causes of importance were as follows:

Still born

Other contributory causes of importance:

Prematurity

Name of operation..... **None** Date of.....

What test confirmed diagnosis?..... Was there an autopsy? **No**

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? **No**

If so, specify.....
(Signed) **L. Clark McVay**, M. D.
BARNES HOSPITAL (Address)

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.

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____
hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____
_____ L. E. _____
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)