

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.

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

33239  
 Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784  
 (b) Township Clayton Primary Registration District No. 101  
 (c) City Clayton (d) Street No. St. Louis County Hospital Registered No. 1523  
 (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.

2. PRINT FULL NAME James Boyd  
 (a) Residence, No. 709 Bismark, Webster Groves, Mo. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 26, 1872

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hrs. or .....min.  
67 2 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil.  
 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) S. Carolina

FATHER 13. NAME Milton Boyd

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

MOTHER 15. MAIDEN NAME Sina Boles

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

17. INFORMANT sister, Jennie Foster (ADDRESS) 711 Bismark, Webster Grove

18. BURIAL, CREMATION, OR REMOVAL PLACE Father Dickert DATE Sept 20, 1938

19. FUNERAL DIRECTOR (ADDRESS) J. Lewis  
Webster Groves

20. FILED SEP 19 1938 Local Registrar. 767

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/15/38 19

22. I HEREBY CERTIFY, That I attended deceased from 7/21/38 9/15/38  
im 9/15/38  
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at 10.45A.M.

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

Cerebral Occlusion?  
Relapsing Embolism?  
 Date of onset 8/14/38  
9/1/38

Other contributory causes of importance:

Name of operation transverse Caesarean Date of 8/15  
 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) James J. David, M. D.  
St. Louis Co. Hosp. (Address)

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STATEMENT BY LICENSED EMBALMER

I, J. Lewis, Licensed Embalmer No. 2027  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed J. Lewis  
Licensed Embalmer No. 2027

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

33239  
Do not use this space.

1. PLACE OF DEATH

(a) County St Louis Registration District No. 784  
 (b) Township Clayton Primary Registration District No. 101 Registered No. 1523  
 (c) City Clayton (d) Street No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (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.

2. PRINT FULL NAME

(a) Residence, No. James Boyd St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-15-38

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
67 2 20

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

OCCUPATION 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 \_\_\_\_\_

Coronary Occlusion  
Postmortal Embolism  
(Myocardial) of Rheumatic  
9-11-38

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

Other contributory causes of importance:  
Rheumatic fever performed to relieve chest pain

MOTHER 13. NAME \_\_\_\_\_

Name of operation postmortem Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

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.

MOTHER 15. MAIDEN NAME \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

FATHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED 979, 1938 J.R. Myer Local Registrar.

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify James F. Boyd, M. D.  
St Louis Co Mo (Address)

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

