

AUG 22 1939

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

25819
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398
 (b) Township Blue Primary Registration District No. 5554
 (c) City Indep. Mo. (d) Street No. 1704 Claramount St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 Mrs. Mollie Lee Boydston

(a) Residence, No. 1704 Claramount St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 21, 1864

7. AGE YEARS 75 MONTHS 3 DAYS 16 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Homemaker

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) Missouri

13. NAME Mathew Selvey

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

15. MAIDEN NAME Elizabeth Frances

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

17. INFORMANT Mrs. Bertha Brady
(ADDRESS) 108 1/2 E Lexington, Indep. Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt Washington DATE July 21-39

19. FUNERAL DIRECTOR (NAME) C.H. Blackman & Son, Inc
(ADDRESS) 2825 Indep. Blvd. K.C. Mo.

20. FILED July 22 1939 F.L. Cook Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 19-39 19

22. I HEREBY CERTIFY That attended deceased from June 20, 1939, to July 19, 1939
 I last saw h. or alive on July 19, 1939. Death is said

to have occurred on the date stated above, at 12:50 AM
 The principal cause of death and related causes of importance were as follows:

Endocarditis

Date of onset 15 days

Other contributory causes of importance: 5.9

Diabetes

15 yrs

Name of operation Chloroform Date of 7/20
 What test confirmed diagnosis? Chloroform Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No Date of injury 7/19, 1939

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 2
 Nature of injury 2

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify

(Signed) Dr. Martin R. Lee M.D.
 (Address) 6500 Menner Rd. K.C. Mo.

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 hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed

H. D. Blackman

Licensed Embalmer No.

3639

P. O. Address

K. C. Mo

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.)

If this body is not embalmed, above space should be left blank.