

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 1 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH11940
State File No.

Registration District No. 114

Primary Registration District No. 5869

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Pemscott
(b) City or town Portageville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
(Specify whetherIn this community
years, months or days)3. (a) PRINT FULL NAME Julia Lee Boyd 3011

3. (b) If veteran, name war W. P. A 3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Rose Campbell Boyd 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Aug 17 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>5</u>	<u>12</u>	hr. min.

9. Birthplace Marshall Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation W P A Worker

11. Industry or business

12. Name Robert Alexander Boyd

18. Birthplace Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Neuware Cross

15. Birthplace Tenn
(City, town, or county) (State or foreign country)

18. (a) Informant's own signature John M Boyd

(b) Address West Pleasant Mo

17. (a) Burial (b) Date thereof 2/10/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Portageville Mo

18. (a) Signature of funeral director W. H. Farnham

(b) Address Portageville Mo

19. (a) Feb 20 1940 (b) Mary W. Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemscott(c) City or town Portageville
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from Feb 3
1940 to Feb 3, 1940

that I last saw him alive on Feb 3
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 1 week

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none made

Of autopsy none made

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (e) Means of injury

23. Signature L. C. Conrad (M. D. or other)

Address Portageville Mo Date signed 2-9-40

109

10K
10-
1K

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 114

Primary Registration District No. 5869

Registrar's No. 4

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Peru
(b) City or town Indian Sea
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Ozilee Lee Bond

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 61 Months 5 Days 14 If less than one day _____ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

20. DATE OF DEATH: Month Feb day 9 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia (lobar)

Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature R. C. Conroy (M. D. or other) _____
Address Portageville Mo

MEDICAL CERTIFICATION

Duration 40 5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

11940 (1940)