

MAY 15 1940 791
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Day's
In this community 28 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Dorothy Mildred Boyd 300

3. (b) If veteran, name war _____ 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 Noble G. Boyd 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased October 7, 1911
(Month) (Day) (Year)

8. AGE: Years 28 Months 5 Days 28 If less than one day hr. _____ min. _____

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Arthur L. Green

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

14. Maiden name Amelia Green

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

16. (a) Informant Noble Grant Boyd

(b) Address 5929 A Southwest Ave.

17. (a) Burial (b) Date thereof April 8, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Lebanon

18. (a) Signature of funeral director Wm. T. Paschedag

(b) Address 2825 N. Grand Blvd.

19. (a) APR 6 1940 (b) J. F. Brubaker
(Date received local health officer) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 3
(If outside city or town limits, write "RURAL")
(d) Street No. 5929 A Southwest Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th
year 1940 hour 1 minute 25 A M.

21. I hereby certify that I attended the deceased from Mar 30
1940, to Apr 5 1940
that I last saw her alive on Apr 4 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Paroxysmal Eclampsia
Pr. eclampsia stage

Due to Pregnancy & toxemia

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

23. Signature J. A. Curle (M. D. or other) MD
Address 5930 Southwest Date signed 4-5-40

Duration 6 days
572 No.

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

146

EMBISSIC 1-47

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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 Guy W. Wilkinson
Licensed Embalmer No. 3575

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. 126990

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 751

Primary Registration District No. 1003

Registrar's No. 3192

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(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.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Dorothy Boyd

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

4. Sex F 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 25 Months 5 Days 25 If less than one day hr. 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) MAY 21 1940 (b) J. F. Cleveland (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 Apr - 5 day 40 year _____ 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 intrauterine eclampsia pre eclampsic stage
Due to _____

Due to Pregnancy - uremia

Other conditions (Include pregnancy within 3 months of death) Delivery 4-4-40 14b

Major findings: Of operations occurred 1 day before Of autopsy death

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 H. F. Cleveland (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

MEDICAL CERTIFICATION

Duration
Underline the cause to which death should be charged statistically.

PHYSICIAN

