

No. 2
4-13-40
-17-39
X23159

FD JAN 20 1941-66
Registration District No. 41

Primary Registration District No. 3030

Registrar's No. 157

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

1. PLACE OF DEATH:
 (a) County Mississippi
 (b) City or town Charleston
 (c) Name of hospital or institution: 401 E. Marshall Street
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 years
 (Specify whether years, months or days) 3

3. (a) PRINT FULL NAME Marion Franklin Boyd
 3. (b) If veteran, name war XXX
 3. (c) Social Security No. XXX

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Nora Boyd
 6. (c) Age of husband or wife if alive XX years
 7. Birth date of deceased November 9 1864
 (Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days 26
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business Farming

12. Name John Boyd

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

14. Maiden name Martina Counts
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Carl Valle

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 12/7/40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Lair-Nunnelee Service

(b) Address Charleston, Missouri

19. (a) 12-6-40 (b) F. D. Verman
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Mississippi
 (c) City or town Charleston
 (If outside city or town limits, write "RURAL")
 (d) Street No. Deal Street
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 5
 year 1940 hour 10 minute 45 a M.

21. I hereby certify that I attended the deceased from Dec. 3 1940 to Dec. 5 1940
 that I last saw him alive on Dec. 5 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
 Duration _____

Due to Cardiovascular

Due to _____

Other conditions 31
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? 745

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature C. C. Presnell (M. D. or other) M.D.

Address Charleston, Mo. Date signed 12/6/40

RECEIVED

District Health Officer No. 2,

District File Number 141-72

Case No. 1/10/41

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 E. E. Pennelee

Licensed Embalmer No. 4164

P. O. Address Charleston, 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, fact should be so stated above.