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FILED MAY 2 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **14486**

Registration District No. **309**

Primary Registration District No. **4185**

Registrar's No. **2**

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

1. PLACE OF DEATH:

(a) County **Spencer, Albany, MO**

(b) City or town **Albany, MO**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**Crossway Farm**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **about 2 mos.**  
(Specify whether)

In this community **life time**  
years, months or days

3. (a) PRINT FULL NAME **Orrville Boyd**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **M** Color or race **W**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife **unknown**

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **and 2 1886**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>55</b>	<b>10</b>	<b>5</b>	hr. _____ min. _____

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

10. Usual occupation **Carpenter**

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name **Lester Boyd**

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

14. Maiden name **Elysa Handus**

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

16. (a) Informant **Mrs. Ada Sage**

(b) Address **Spencer, MO**

17. (a) **Funeral** (b) Date thereof **2 26 41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Crossway Farm, Albany, MO**

18. (a) Signature of funeral director **Wm. H. Phillips**

(b) Address **Spencer, MO**

19. (a) **July 8, 1941** (b) **Wm. H. Phillips**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Spencer, MO**

(c) City or town **Spencer**  
(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.?  0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **7** A.M.  
year **1941** hour **100** minute **30**

21. I hereby certify that I attended the deceased from **Nov 30**  
\_\_\_\_\_ 19**40** to **Jan 7** 19**41**  
that I last saw him alive on **Jan 7** 19**41**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Angina Pectoris**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature **J. Y. Bangs** (M. D. or other) \_\_\_\_\_  
Address **Albany, MO** Date signed **2/8/41**

**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 \_\_\_\_\_

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, fact should be so stated above.**