

FILED JUN 19 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18511

Registration District No. 005

Primary Registration District No. 534

Registrar's No.

1. PLACE OF DEATH:

(a) County NEW MADRID  
 (b) City or town CATRON  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: NO  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution NO  
 In this community ALL OF LIFE  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEW MADRID  
 (c) City or town CATRON  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

MARY LEE BOYD

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 14  
 year 1941 hour 5:00 minute \_\_\_\_\_ P. 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: Whooping Cough  
By Record of Mother  
 Duration: About 1 week

4. Sex FEMALE 5. Color or race Colored 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife NO 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: MAY 26 - 1941  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 18 hr. \_\_\_\_\_ min.

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

10. Usual occupation: Child

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

12. Name TOM BOYD

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

14. Maiden name ANNA LEE (City, town, or county) (State or foreign country)

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

16. (a) Informant TOM BOYD

(b) Address CATRON, MO

17. (a) RURAL (Burial, cremation, or removal) (b) Date thereof: JUN 14-1941 (Month) (Day) (Year)

(c) Place: burial or cremation CATRON

18. (a) Signature of funeral director NO

(b) Address \_\_\_\_\_

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

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

Major findings: Of operations NO

Of autopsy NO

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) NO

(b) Date of occurrence NO

(c) Where did injury occur? NO (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? NO

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

23. Signature Leo Hedgcock (City or town) (State) Dep. Coroner

Address June 14 New Madrid, MO Date signed \_\_\_\_\_

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

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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..... *No* .....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 605

Primary Registration District No. 584

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County New Madrid  
 (b) City or town Como  
(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 \_\_\_\_\_  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State MO (b) County New Madrid  
 (c) City or town Como  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Lee Boyd  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color of race Cal 6. (a) Single, widowed, married, divorced 8

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 \_\_\_\_\_ Months \_\_\_\_\_ Days 18  
 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 8-27-41 (b) D. Scott Huat  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month June day 14  
 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

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

Other conditions \_\_\_\_\_  
(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? \_\_\_\_\_

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

23. Signature Leo Hedgcock M. D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

S-18511 1941

