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v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 31 1945

State File No. 23932

Registration District No. 128 — Primary Registration District No. 2000 — Registrar's No. 524

1. PLACE OF DEATH:

(a) County: Greene

(b) City or town: Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Springfield Baptist Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Arkansas (b) County: Boone

(c) City or town: Alpena (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: Ayers Hiram Boyd

3. (b) If veteran, name war: Unk.

3. (c) Social Security No.: Unk.

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Frona Boyd

6. (c) Age of husband or wife if alive: 66 years

7. Birth date of deceased: Jan. (Month) 26 (Day) 1876 (Year)

8. AGE: Years: 69 — Months: 5 — Days: 5 — If less than one day: ____ hr. ____ min.

9. Birthplace: Boone Co. (City, town, or county) Ark. (State or foreign country)

10. Usual occupation: Farmer & Stockman

11. Industry or business: Agriculture

FATHER 12. Name: Tillman Boyd

FATHER 13. Birthplace: Unk. (City, town, or county) Tenn. (State or foreign country)

MOTHER 14. Maiden name: Margaret Carson

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

16. (a) Informant: Mrs. A. H. Boyd

(b) Address: Alpena, Ark.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 3, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Alpena, Ark.

18. (a) Signature of funeral director: A. C. Christeson

(b) Address: Harrison, Ark.

19. (a) 7-11-45 (Date received local registrar) (b) A. W. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July day: 1 year: 1945 hour: 8 minute: 45 P. M.

21. I hereby certify that I attended the deceased from June 28, 1945, to July 1, 1945, that I last saw him alive on July 1, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Post operative embolus (Sudden or near)	
Due to: Gangrene of rt. foot	3 wks.
Diabetes Mellitus	6 or 7 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations: Gragrene of foot

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)

(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? (e) Means of injury

23. Signature: Guy D Calloway (M. D. or other) MD

Address: Springfield Mo Date signed: 7/11/45

98* (Licensed Embalmer's Statement on Reverse Side)

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.