

FILED MAR 6 1947

Registration District No. **41947**

Primary Registration District No. **3075**

Registrar's No. **59**

1. PLACE OF DEATH:

(a) County **Stoddard**
(b) City or town **Dexter**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **most of life** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Stoddard**
(c) City or town **Dexter**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mattie May Boyd**

3. (b) If veteran, name war _____ **3. (c) Social Security** No. **None**

4. Sex **Female** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **W. L. Boyd** **6. (c) Age of husband or wife if alive** **73** years
7. Birth date of deceased **May 7 1873**
(Month) (Day) (Year)

8. AGE: Years **73** Months **9** Days **19** If less than one day hr. _____ min.

9. Birthplace _____ **Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business _____

MOTHER FATHER
12. Name **Dr. John Nickle**
13. Birthplace _____ **Arkansas**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Mc Card**
15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mylene Madden**
(b) Address **Dexter, Missouri**
17. (a) Burial **(b) Date thereof** **2-27-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Sycamore Cemetery**

18. (a) Signature of funeral director **Hander Funeral Home**
(b) Address **Campbell, Missouri**
19. (a) 428-471 **(b) Margaret Truett**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **26**
year **1947** hour _____ minute **12:10 A.M.**
21. I hereby certify that I attended the deceased from **24 Feb**
1947 to **25 Feb** **1947**
that I last saw her alive on **25 Feb** **1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**

Due to **Toxemia and secondary failure Pneumococcus**

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

Major findings:
Of operations _____
Of autopsy **107A**

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)
23. Signature **J. L. W. Dahl** (M. D. or other) **MD**
Address **Dexter, Mo** **Date signed** **27 Feb 47**

Duration **2 hours**
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

53
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369

RECEIVED

District Health Office No. 2,

District File Number 347-296

Date Filed 3-4-47

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 Christina M. Landess

Licensed Embalmer No. 4227

P. O. Address Campbell, Missouri

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.