

1917

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 19 1949

 BIRTH NO. 49-012995 REG. DIST. NO. 217 PRIMARY REG. DIST. NO. 5787 Registrar's No. 5-

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Charleston (Rural)</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Charleston (Rural)</u>	
c. LENGTH OF STAY (In this place) <u>life</u>		d. STREET ADDRESS (If rural, give location) <u>Route 1, Box 47</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4 1/2 mi. south. Route 1 /</u>			

3. NAME OF DECEASED (Type or Print) <u>O. W. Boyd</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 10, 1949</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 7, 1949</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charleston, Missouri /</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Joshua Boyd</u>	13b. MOTHER'S MAIDEN NAME <u>Margarene Clark</u>	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME <u>O. W. Boyd, R. 1, Box 47, Charleston, Mo.</u>	ADDRESS <u>Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malnutrition</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>inability to retain nourishment</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>772.0</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 7, 1949, to Jan. 10, 1949, that I last saw the deceased alive on Jan. 10, 1949, and that death occurred at 5:30A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Anne Lee Clayton, midwife</u>	23b. ADDRESS <u>R. 1, Box 91 A, Charleston, Mo.</u>	23c. DATE SIGNED <u>1/12/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan. 10, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Charleston, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>1-12-49</u>	REGISTRAR'S SIGNATURE <u>Mrs. Helen Bondurup</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Sparks</u>	ADDRESS <u>Charleston, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10. 48

RECEIVED

District Health Office No. 2,

District File Number 149-77

Date Filed 1-17-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Frank Sparks

Signed.....
Student Embalmer

Licensed Embalmer No. 3455

P. O. Address Cape Girardeau, 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.