

FILED MAR 8 1949

DEPARTMENT OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6966**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **384**

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY _____ |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN (Rural) <b>Koch</b> |  | c. LENGTH OF STAY (in this place) <b>205</b> | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>                                     |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>                              |  |  | d. STREET ADDRESS (If rural, give location) <b>2306 Eugenia</b>   |  |  |

|  |                               |  |   |   |  |
|--|-------------------------------|--|---|---|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <b>Andrew</b> b. (Middle) <b>Clifton</b> c. (Last) <b>Boyd</b> |                               |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>2-14-49</b>            |   |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>Negro</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b> | 8. DATE OF BIRTH <b>12-27-07</b>                                | 9. AGE (In years last birthday) <b>41</b> | IF UNDER 1 YEAR Months <b>1</b> Days <b>17</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Odd Jobs</b>      |                               | 10b. KIND OF BUSINESS OR INDUSTRY _____                              | 11. BIRTHPLACE (State or foreign country) <b>Memphis, Tenn.</b> |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>     |

|                                     |  |                                   |
|-------------------------------------|--|-----------------------------------|
| 13a. FATHER'S NAME <b>Jack Boyd</b> | 13b. MOTHER'S MAIDEN NAME <b>Sadie Lindsey</b> | 14. NAME OF HUSBAND OR WIFE _____ |
|-------------------------------------|--|-----------------------------------|

|  |  |   |               |
|--|--|---|---------------|
| 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. <b>490-12-4135</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Hospital Records, Robert Koch Hosp</b> | ADDRESS _____ |
|--|--|---|---------------|

|  |  |                       |  |                                  |
|--|--|-----------------------|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION |  | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Tuberculosis</b>   |  | DUE TO (b) _____      |  | <b>???</b>                       |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | DUE TO (c) _____      |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.          |  | <b>002X</b>           |  |                                  |

|                              |  |  |
|------------------------------|--|--|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------|--|--|

|   |  |   |
|---|--|---|
| 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) _____ | 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 **7-27-48**, to **2-14-**, 19 **49**, that I last saw the deceased alive on **2-14-**, 1949, and that death occurred at **7:40A** m., from the causes and on the date stated above.

|   |  |                                 |
|---|--|---------------------------------|
| 23a. SIGNATURE (Degree or title) <b>John Raymond Beem, M.D.</b> | 23b. ADDRESS <b>Robert Koch Hospital</b> | 23c. DATE SIGNED <b>2-14-49</b> |
|---|--|---------------------------------|

|   |                          |  |   |
|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> | 24b. DATE <b>2-18-49</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>GREEN WOOD</b> | 24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b> |
|---|--------------------------|--|---|

|   |  |   |                          |
|---|--|---|--------------------------|
| DATE REC'D BY LOCAL REG. <b>2-17-49</b> | REGISTRAR'S SIGNATURE <b>Shirley L. Lupton</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. C. Pettis</b> | ADDRESS <b>3030 Bell</b> |
|---|--|---|--------------------------|

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

9600

**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.

Student .....  
Student Embalmer

Signed Esther A. Harris

Licensed Embalmer No. 4458

P. O. Address 3510 Bell Ave

**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.