MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space. 12455

791

1. PLACE OF DEATH

County .... Registration District No. 1003 File No. ....

Township St Louis Primary Registration District No. .... Registered No. 2977

City St Louis (No. City Hospital #2 St. .... Ward)

2. FULL NAME Homer Boyd

(a) Residence. No. 2831 Lawton St., 21 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS	
3. SEX	Male
4. COLOR OR RACE	Col.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)	Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF	
6. DATE OF BIRTH (MONTH, DAY AND YEAR)	Jan. 25, 1880
7. AGE — Years / Months / Days / If LESS than 1 day, ...hrs. or ...min.	49 / 1 / 12
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work	Porter
(b) General nature of industry, business, or establishment in which employed (or employer)	
(c) Name of employer	
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	Miss
10. NAME OF FATHER	Abe Boyd
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)	Miss.
12. MAIDEN NAME OF MOTHER	Not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)	Miss
14. INFORMANT	Anna F. Woodard
(Address)	City Hospital #2
15. FILED Mar 8 1929	May R. Starkey, REGISTRAR

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH (MONTH, DAY AND YEAR)	3-7-1929
17. I HEREBY CERTIFY, That I attended deceased from	8-27-1928, to 3-7-1929
that I last saw him alive on	3-7-1929, and that death occurred, on the date stated above, at 4:20 P.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:	Chr. nephritis (duration) yrs. 8 mos. 1 ds.
CONTRIBUTORY (SECONDARY)	Chr. myocarditis (duration) yrs. 2 mos. ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?	
DID AN OPERATION PRECEDE DEATH?	no — DATE OF
WAS THERE AN AUTOPSY?	no
WHAT TEST CONFIRMED DIAGNOSIS?	Clin.
(Signed)	R. Cunningham, M.D.
3/8, 1929 (Address)	2945 Lawton

131

93c

1290

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Washington Park	Mar. 8 1929
20. UNDERTAKER J H Harrison	ADDRESS 2906 Lawton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

25 2 2 2