

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

Do not use this space.

111
JAN 2 1931
JAN 23 1931

4381

1. PLACE OF DEATH
 County Madison Registration District No. 891
 Township Madison Primary Registration District No. 4540
 City Madison (No. _____) St. _____ Ward _____

2. FULL NAME
John Boyd
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 20 yrs. 9 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 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 11 1931

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>20</u>	<u>9</u>	<u>14</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work School teacher
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Madison Mo
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Frank Boyd

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Madison Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Marie Boyd

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Madison Mo
 (STATE OR COUNTRY)

14. INFORMANT Mr. Boyd
 (Address) Janney Hill mo

15. FILED 1/13 1931 T. B. Pike, Jr. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1931 to Jan 11 1931, that I last saw him alive on Jan 11 1931, and that death occurred, on the date stated above, at 2:25 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemia
115B
30
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) infection
across
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

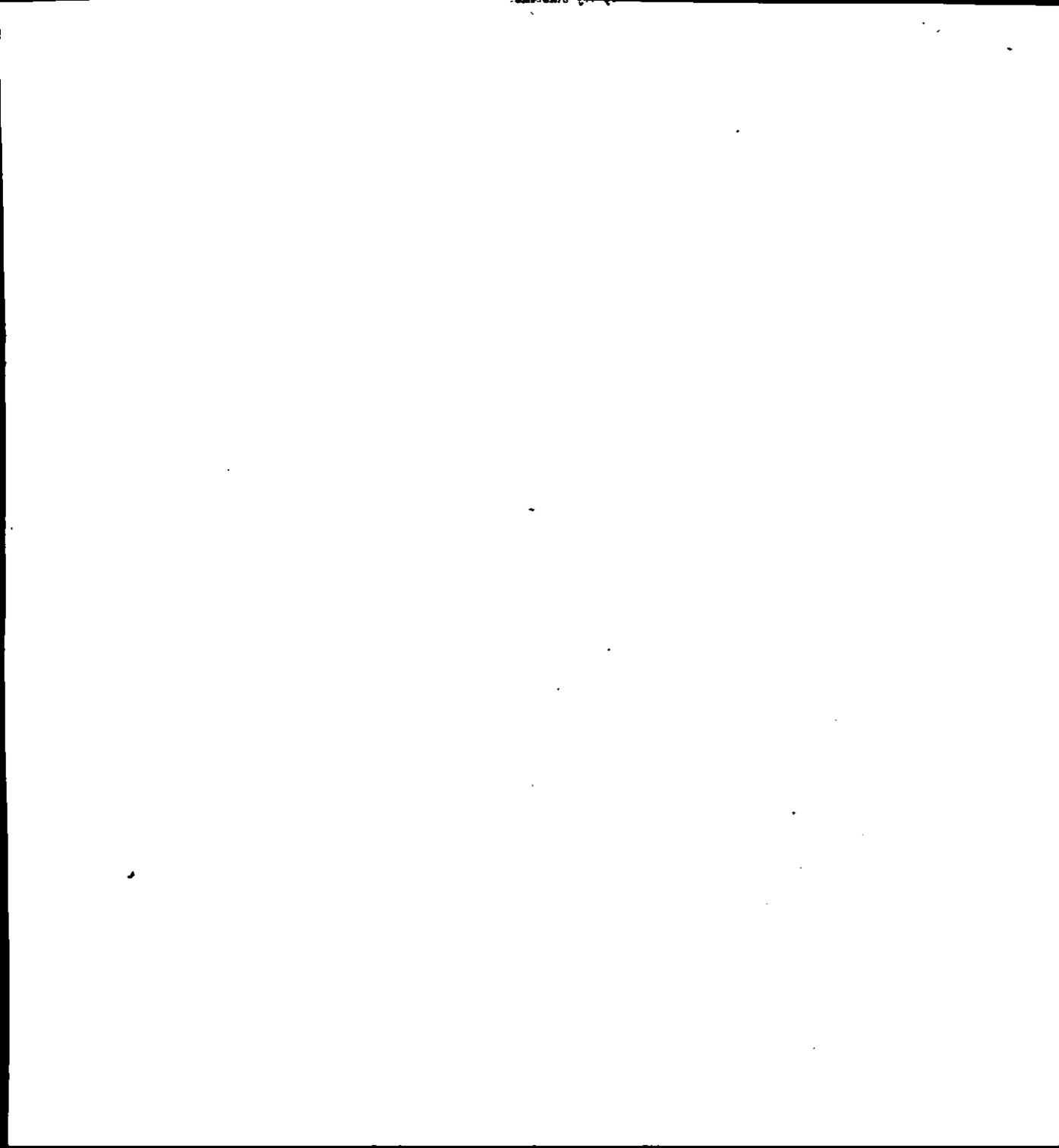
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) G. H. Conway M. D.
 _____ 19 _____ (Address) Piedmont Mo

*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 Masonic Cem DATE OF BURIAL Jan 13 1931

20. UNDERTAKER Yates und. co. ADDRESS Piedmont



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Wayne Registration District No. 891 File No. _____
 Township Clinton Primary Registration District No. 4540 Registered No. 2
 City Dudman (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 100 St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 27/3/1910

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
20 9 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT

(Address)

15. FILED 1/31 1931 T. C. Bile REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1931

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Septicemia
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Infection from abscess
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Small abscess at the right corner of the mouth
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL 1085 115B

WHAT TEST CONFIRMED DISEASE? _____ (Signed) _____, M. D.

(Address)

*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

19

20. UNDERTAKER ADDRESS

REC- SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-4381