

S. No. 2
M-5-43
5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12570

State File No. _____
Registrar's No. **4275**

Registration District No. **15** Primary Registration District No. **1003**

FILED MAY 15 1944

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

1. PLACE OF DEATH:
(a) County **ST. LOUIS CITY**
(b) City or town _____
(c) Name of hospital or institution: **BARNES HOSPITAL**
(d) Length of stay: In hospital or institution **7 days**
In this community _____ years, months or days

3. (a) PRINT FULL NAME **EDWIN JOSEPH BOYD**
3. (b) If veteran, name war *********
3. (c) Social Security No. **493-01-9146**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Althea Ruth Boyd**
6. (c) Age of husband or wife if alive **50** years
7. Birth date of deceased **February 2 1882**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 **3** **6** hr. min.

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

10. Usual occupation **Superintendent**

11. Industry or business **Framstark Chemical Co**

MOTHER FATHER
12. Name **Archie E. Boyd**
13. Birthplace **Missouri**
14. Maiden name **Luella Fielding**
15. Birthplace **Missouri**

16. (a) Informant **Althea Boyd**
(b) Address **4499 Lee Ave**

17. (a) **Burial** (b) Date thereof **May 10 1944**
(City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **Petz Brothers**
(b) Address **3029 La Fayette Ave**

19. (a) **MAY 9 1944** (b) **J. F. Breda**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO.** (b) County **ST. LOUIS**
(c) City or town **St. Louis**
(d) Street No. **4499 B. Lee Ave**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **8**
year **1944** hour **10** minute **50 A.** M.

21. I hereby certify that I attended the deceased from **MAY 1**, 19 **44** to **MAY 8**, 19 **44**;
that I last saw h. i. m. alive on **MAY 8**, 19 **44**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis** Duration _____
Due to **Hypertensive Cardiovascular disease** **7 years**
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____

PHYSICIAN

Of autopsy **Coronary thrombosis -
Mural thrombus of left ventricle**
Underline the cause to which death should be charged statistically.

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) (e) Means of injury _____
23. Signature **M. C. Abney** (M. D. or other) _____
Address **BARNES HOSPITAL** Date signed **5/8/44**

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.....
Frank J. Jones

AA Licensed Embalmer No. *2245*

P. O. Address. *St. Louis, 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.