

FILED OCT 1 1947

Registration District No. **47**

Primary Registration District No. **3008**

Registrar's No. **328**

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

1. PLACE OF DEATH:

(a) County **Callaway**
(b) City or town **Fulton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **State Hospital No. 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 days**
(Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Callaway**
(c) City or town **Fulton**
(If outside city or town limits, write "RURAL")
(d) Street No. **105 West 4th St.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

OBE BOYD

(b) If veteran, name war

(c) Social Security No.

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **M.**
(b) Name of husband or wife **Annie Boyd** 6. (c) Age of husband or wife if alive years **9** 1879
7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 **0** **6** hr. min.

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

10. Usual occupation **cook**

11. Industry or business

MOTHER FATHER { 12. Name **John M. Boyd**
13. Birthplace **Indiana** (City, town, or county) (State or foreign country)
14. Maiden name **Marian Thompson**
15. Birthplace **Indiana** (City, town, or county) (State or foreign country)

16. (a) Informant **Star Boyd**

(b) Address **111 West 6 St. Fulton**

17. (a) **Burial** (b) Date thereof **Sept 18, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Bloomfield, Mo**

18. (a) Signature of funeral director: **Glen Y. Mangin**

(b) Address **712 Cantor St. Fulton, Mo**

19. (a) **9-18-1947** (b) **Joan M. Mansueti**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **15**
year **1947** hour **4.10 PM** minute M.

21. I hereby certify that I attended the deceased from **9-7-47** 19 to **9-15-47** 19
that I last saw him alive on **9-15-47** and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary edema**
dilatation right heart
(decompensation)
Due to
Due to

Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **95**
Of autopsy

PHYSICIAN

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 **D. G. Baldwin** (M. D. or other)
Address **Fulton, Mo** Date signed **9/15/47**

Date Filed 9-30-47

District File Number

District Health Officer No. 9,

RECEIVED

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.....

Theodore Skinner, Jr

Registered Apprentice No. 55

working under my personal supervision.

Signed *Glen G. Mauhin*

Licensed Embalmer No. 2725

P. O. Address *Fulton 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.