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

Do not use this space.

1929

1. PLACE OF DEATH
County St Genevieve. Registration District No. 783
Township Salisbury Primary Registration District No. 6029
City (No. St. Ward)
File No. 12088
Registered No.

2. FULL NAME Mrs Alice Boyd

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
72	9	24	

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

9. BIRTHPLACE (CITY OR TOWN) St Genevieve Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Reuben Walton
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Grayson Co Va
12. MAIDEN NAME OF MOTHER Eliza J. Ward
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Green Co Tenn

14. INFORMANT Ford Walton
(Address) Farmington Mo

15. FILED 3/16, 1929 Mrs H N Vaugh
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 14 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Mar 14, 1929
that I last saw her alive on Feby 3, 1929, and that death occurred, on the date stated above, at 11 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis
Chronic Interstitial Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Home
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) R Coppleberry, M. D
March 14, 1929 (Address) Farmington 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 Mayberry Cemetery
DATE OF BURIAL 3/16 1929
20. UNDERTAKER Farmington Undertaking Co
ADDRESS Farmington Mo

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 St. Genevieve Registration District No. 783 File No.
Township Salisbee Primary Registration District No. 6029 Registered No.
City (No. St. Ward)

2. FULL NAME Mrs Alice Boyd

(a) Residence. No. St. Ward. (If nonresident, give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 20 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	72	9	24	

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)

PARENTS
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 3/16, 1929 Mrs H N Vaught REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/14 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

... (duration) ...yrs...mos...ds.

CONTRIBUTORY (SECONDARY) ...
... (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?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ..., M. D.
, 19 (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

SUPPLEMENTARY

SHALL NOT RECEIVE A FEE ... TIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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