

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

Do not use this space.

31668

OGY 24 1097

1. PLACE OF DEATH

County Ray Registration District No. 1743 File No. _____
 Township Orwick Primary Registration District No. H44B Registered No. 27
 City Orwick (No. _____) St. _____ Ward _____

2. FULL NAME Lucinda Margaret Loyd

(a) Residence. No. _____ 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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 29 1878

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<u>89</u>	<u>2</u>	<u>27</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Kentucky
 (STATE OR COUNTRY)

10. NAME OF FATHER Dillard M^cMullen

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

12. MAIDEN NAME OF MOTHER Annie Reynolds

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

14. INFORMANT Wm Loyd
 (Address) Orwick Mo

15. FILE Sept 27 19 2 E E E REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
 16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 26 19 29

17. I HEREBY CERTIFY, That I attended deceased from Sept 16, 1929, to Sept 24, 1929, that I last saw h. ex. alive on Sept 26, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Effects of Broken Hip (Accidentally)
12/12 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Senility
102 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

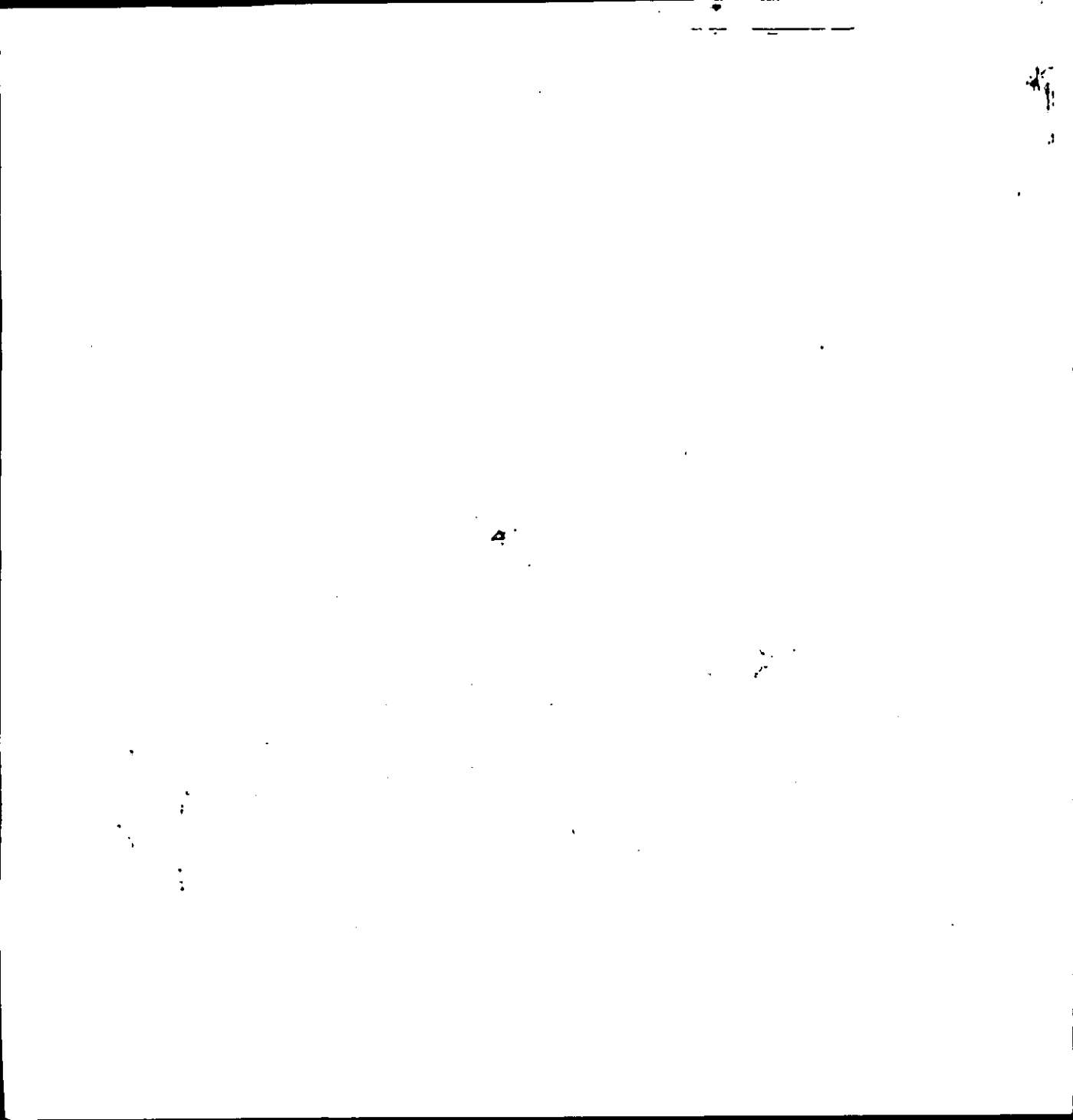
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) L. E. Ellis, M. D.
 , 19 (Address) Orwick 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 Riffe Cemetery DATE OF BURIAL Sept 27 19 29

20. UNDERTAKER C. V. Gibson ADDRESS Orwick 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 Ray Registration District No. 743 File No. _____
 Township _____ Primary Registration District No. 4445 Registered No. 27
 City Ovick (No. _____) St. _____ Ward _____

2. FULL NAME

Lucinda Margaret Loyd
 (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 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 wid
(write the word)

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.

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 Oct 31 1979 L E Ellis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 26 1979

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:

Broken left hip
accidental fall on
the ground while
working (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 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
REGISTRAR

S-31668