

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

Do not use this space.

38156

**1. PLACE OF DEATH**

County Ray Registration District No. 744  
 Township Richmond Primary Registration District No. 3976 B  
 City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Margaret E. 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 Female  
 4. COLOR OR RACE white  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John D. Loyd  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 10 1880  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
48 11 17

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

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

10. NAME OF FATHER John Mober  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER Don't know  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia  
 (STATE OR COUNTRY)

14. INFORMANT John D. Loyd  
 (Address) Rayville Mo.  
Dec 9, 19 29 E. E. Loyd REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

15. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 27 1929  
 17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1929, to Nov 27 1929, that I last saw her alive on Nov 25 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Myocarditis  
 930 (duration) yrs. mos. 14 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? yes  
 WHAT TEST CONFIRMED DIAGNOSIS? Physical exam  
 (Signed) D. O. Jones, M. D.  
 19 (Address) Rayville 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 Union Cemetery DATE OF BURIAL 11 28 19 29  
 20. UNDERTAKER J. S. Rawlaw ADDRESS Rayville Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Every statement should be carefully supplied.

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