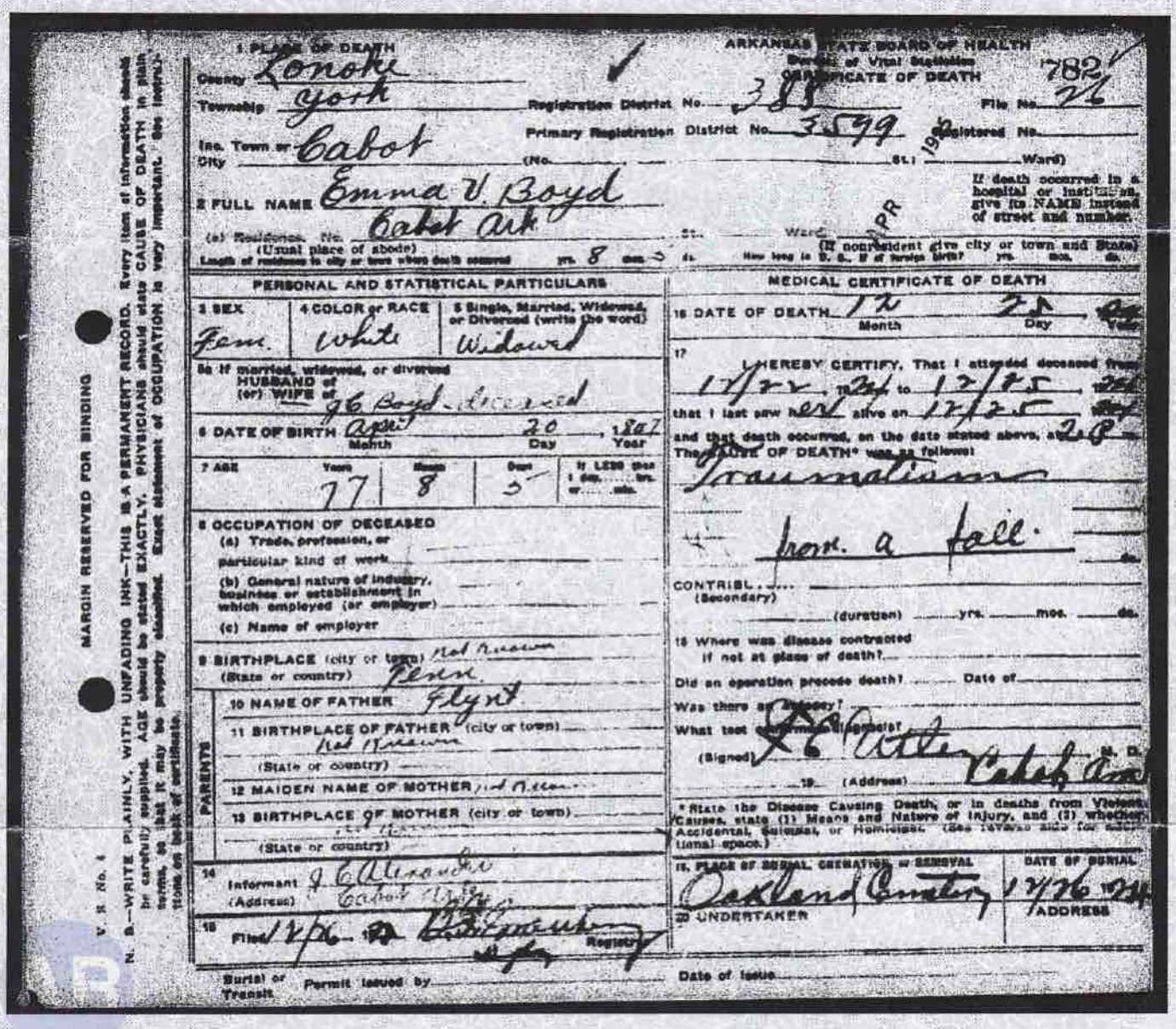
STATE OF ARKANSAS



1. PLACE OF DEATH
County Lonoke
Township York
Reg. Town or City Cabot
2. FULL NAME Emma V. Boyd
(a) Residence. No. Cabot Ark
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 8 mos. 5 ds.

ARKANSAS STATE BOARD OF HEALTH
Bureau of Vital Statistics
CERTIFICATE OF DEATH 782
Registration District No. 385
Primary Registration District No. 3599
File No. 72
Registered No.
(No. St. Ward)
If death occurred in a hospital or institution, give its NAME instead of street and number.
(If nonresident give city or town and State)
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)
Fem.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. G. Boyd - deceased

6 DATE OF BIRTH April (Month) 20 (Day) 1857 (Year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	8	5	

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) Not Known
(State or country) Penn.

PARENTS
10 NAME OF FATHER Flynt
11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant J. C. Alexander
(Address) Cabot Ark.

15 Filed 12/26 19 25 Registrar

Burial or Transit Permit issued by Date of issue

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 (Month) 25 (Day) 25 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 12/22 19 25 to 12/25 19 25
that I last saw her alive on 12/25 19 25
and that death occurred, on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Traumatism
from a fall.
CONTRIBL. (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 tests confirmed diagnosis?
(Signed) J. C. Alexander M. D.
19 (Address) Cabot Ark.

* State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

21. PLACE OF BURIAL, CREMATION, or REMOVAL	DATE OF BURIAL
Oakland Cemetery	12/26 19 25
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

V. S. R. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THE ARKANSAS DEPARTMENT OF HEALTH.

ARKANSAS DEPARTMENT OF HEALTH SEAL LITTLE ROCK, ARK.

Paul W. Johnson
Paul W. Johnson
State Registrar

August 16, 2012

WARNING: A REPRODUCTION OF THIS DOCUMENT RENDERS IT VOID AND INVALID. DO NOT ACCEPT UNLESS EMBOSSED SEAL OF THE ARKANSAS DEPARTMENT OF HEALTH IS PRESENT. IT IS ILLEGAL TO ALTER OR COUNTERFEIT THIS DOCUMENT.

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THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER. THIS IS WATERMARKED PAPER. DO NOT ACCEPT WITHOUT FIRST HOLDING TO LIGHT TO VERIFY WATERMARK.