WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—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.

REC'D JAN 11 1939

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

40715
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 791
(b) Township ..... Primary Registration District No. 1003 Registered No. 10407
(c) City St. Louis (d) Street No. BARNES HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 4 or Lydia Jane Boyle
(a) Residence, No. 7508 Wellington St. NR Clayton, Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
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 Thomas Boyle
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown
7. AGE abt. YEARS 79. MONTHS DAYS If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. retired
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri 5

FATHER
13. NAME Charles Stone 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 1

MOTHER
15. MAIDEN NAME Caster
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Marie Boyer ~~Bauer~~ ~~Hospital~~ 7508 Wellington Drive
18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove Cem DATE 12-3 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alexander & Son 6175 Delmar
20. FILED DEC 3 1938 J. F. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-1, 1938

22. I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1938 to Dec. 1, 1938
I last saw her alive on Dec., 19..... Death is said to have occurred on the date stated above, at 6 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypertension	2
Hypertensive heart dis.	2
Other contributory causes of importance:	
Cerebral Arteriosclerosis	2

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Eva L. Evans, Jr., M. D.
(Address) BARNES HOSPITAL

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed J. Wm. Binkley

Licensed Embalmer No. 3653

P. O. Address St. Louis 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, above space should be left blank.