

REG'D OCT 14 1939  
791  
Registration District No. 1003

Primary Registration District No.

1. PLACE OF DEATH: **1**  
(a) County **St. Louis.**  
(b) City or town **St. Louis, Mo.**  
(c) Name of hospital or institution: **City Infirmiry. Hospital.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **May 7, 1935.**  
(Specify whether  
In this community **Life.**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED: **1**  
(a) State **Missouri.** (b) County **St. Louis.**  
(c) City or town **St. Louis, Mo.** **13**  
(If outside city or town limits, write "RURAL.")  
(d) Street No. **5800 Arsenal St.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. **U.S.A.** years

3. (a) PRINT FULL NAME **Lena Boyle** **H07**  
8. (b) If veteran, name war **Unknown** 8. (c) Social Security No. **Unknown**  
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife If alive \_\_\_\_\_ years  
7. Birth date of deceased **November 21, 1867.**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **September**, day **21**, year **1939** hour **5:00** minute \_\_\_\_\_ a. M.  
21. I hereby certify that I attended the deceased from **May 7,** 19**35**, to **September 21,** 19**39**, that I last saw her alive on **September 21,** 19**39**, and that death occurred on the date and hour stated above.

8. AGE: Years **71** Months **8** Days **X** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace **St. Louis, Mo.** **American.**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Dependent.**

Immediate cause of death **Chronic Myocarditis.**  
Duration \_\_\_\_\_  
Due to **Generalized Atherosclerosis**  
Due to **Senile Calcification**  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

MOTHER FATHER  
11. Industry or business **X**  
12. Name **Unknown** **7**  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
16. (a) Informant's own signature **E. Moloney**  
(b) Address **5800 Arsenal St.**  
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9-22-39** (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary Sept 22-39**  
18. (a) Signature of funeral director **Wronschurg Ltd. Co.**  
(b) **SEP 22 1939** **Flourent**  
19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (City, town, or county)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **E. J. Breen** (M. D. or other) \_\_\_\_\_  
Address **5800 Arsenal** Date signed \_\_\_\_\_

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.

I X1931

**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.

*No Embalmer*

Signed.....  
.....  
Licensed Embalmer No.....  
P. O. Address.....

**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.**