

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16482

State File No.

Registrar's No.

3960

Registration District No. 7911

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ENROUTE CITY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 42 YEARS (Specify whether years, months or days)

3. (a) PRINT FULL NAME JOHN F. BOYLE 460

8. (b) If veteran, name war NONE 8. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased MAR. 10 - 1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 21 If less than one day hr. min.

9. Birthplace ILL.
(City, town, or county) (State or foreign country)

10. Usual occupation CONDUCTOR RETIRED

11. Industry or business PUBLIC SERVICE CO.

12. Name GEORGE BOYLE

13. Birthplace IRELAND
(City, town, or county) (State or foreign country)

14. Maiden name ANNA McGUIRE

15. Birthplace IRELAND
(City, town, or county) (State or foreign country)

16. (a) Informant Margaret Maher
(b) Address 1118 S. 10th St.

17. (a) BURIAL (b) Date thereof 5 - 4 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GRANT FORK, ILL.

18. (a) Signature of funeral director Hullen & Kelly

(b) Address 1416 N. Taylor Ave

19. (a) MAY 2 1940 (b) J. F. [Signature]
(Date received at registrar's office) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town ST. LOUIS 6
(If outside city or town limits, write "RURAL")
(d) Street No. 1388 BURD AVE
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

No attending physician MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st
year 1940 hour 12. minute 40 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis;
Chronic Interstitial Nephritis.

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 8 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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 [Signature] (M. D. or other) _____

Address [Signature] Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Clement McNeary

Licensed Embalmer No. 3732

P. O. Address

St. Louis

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.