

FILED MAY 12 1942

1537

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 1/4 hours
(Specify whether
In this community 13 1/4 hours
years, months or days)

3. (a) PRINT FULL NAME

Frank Boyle
Frank Boyle

3. (b) If veteran, name war

3. (c) Social Security No. none

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased (Month) Apr (Day) 19 (Year) 42

8. AGE:	Years	Months	Days	If less than one day
X	1	X	X	1 hr. 45 min.

9. Birthplace MO CO (City, town, or county) (State or foreign country) U

10. Usual occupation U

11. Industry or business X

12. Name Frank Boyle

13. Birthplace Garden City MO (City, town, or county) (State or foreign country) 0

14. Maiden name Viola Childs Boyle

15. Birthplace Garden City MO (City, town, or county) (State or foreign country) 1

16. (a) Informant Frank Boyle

(b) Address Garden City MO

17. (a) Burial (b) Date thereof 4-19-42 (Month) (Day) (Year)

(c) Place: burial or cremation Garden City MO

18. (a) Signature of funeral director J. M. Hoffmann

(b) Address Garden City MO

19. (a) Apr 19 42 (Date received local registrar) (b) M. W. Cron (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 19
(c) City or town Garden City (If outside city or town limits, write "RURAL") 0
(d) Street No. 1 (If rural, give location)
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 19 year 1942 hour 3 minute 40 A.M.

21. I hereby certify that I attended the deceased from 4/19/42 to 4/19/42 that I last saw her alive on 4/19/42 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage Duration 1 1/2 hr.

Due to Toxemia of Pregnancy of Maternal

Due to 160a

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Cerebral Hemorrhage
Multiple Petechial Hemorrhages

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?

(Specify type of place) While at work? (e) Means of injury +
23. Signature Ralph K. Hillman (M. D. or other) M.D.
Address 231 W 47 Date signed 4/19/42

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.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. _____
Registrar's No. 1537

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kennett City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Infant Boyles

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Charles Elmer Boyles

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

14. Maiden name Viola Childs

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

16. (a) Informant Chas. E. Boyles

(b) Address Pleasant Hill Mo.

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 28, 1948 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 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?
_____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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