

FILED AUG 25 1944

State File No. _____

Registration District No. 318

Primary Registration District No. _____

Registrar's No. 6892

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:
St. Johns Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County St. Louis ^{9B}

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") ^{3NR}

(d) Street No. Kirkwood, Missouri.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Felix K. Boyle

3. (b) If veteran, name war None

3. (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 Unknown, abot 1884
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>Abt. 60</u>	<u>--</u>	<u>--</u>	<u>--</u>	hr. _____ min.

9. Birthplace Ireland. ⁴
(City, town, or county) (State or foreign country)

10. Usual occupation Professor of Languages

11. Industry or business _____

12. Name Unknown Boyle

13. Birthplace Ireland. ⁴
(City, town, or county) (State or foreign country)

14. Maiden name Unknown.

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

16. (a) Informant Wm. P. Wenzel
(b) Address 7170 Delmar Blvd.

17. (a) Burial (b) Date thereof Aug. 8, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Donnell Nechaes
(b) Address 1431 Union Blvd.

19. (a) AUG 7 (b) J. F. Orndorff 1944
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 5
year 1944 hour 6 minute 50 p. M.

21. I hereby certify that I attended the deceased from June
1, 1944 to Aug 5, 1944;
that I last saw him alive on Aug 5, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____
General Carcinomatosis ^{6 months}
originating in stomach ^{1 year}

Due to _____

Due to _____

Other conditions Ho
(Include pregnancy within 3 months of death)

Major findings: general carcinoma

Of operations _____

Of autopsy _____

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? _____

While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature Wm. P. Wenzel (M. D. or other) _____
Address Wm. P. Wenzel Date signed 8/7/44

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

MOTHER FATHER

afred .20

afro .1

.frra .1

afro .1

8

.frra .1

afro .1

afro .1

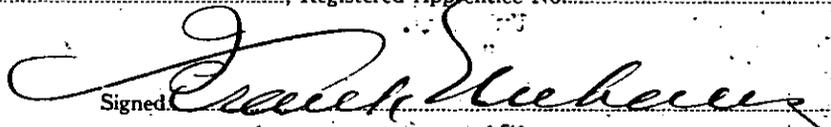
STATEMENT BY LICENSED EMBALMER

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.....

2915

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, fact should be so stated above.