

S. No. 2
DOM-5-43
Rev. 5-17-39
I X36871

FILED MAY 26 1945
318

Registration District No. _____
Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis,

(b) City or town St. Louis,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: DePaul Hospital
(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 Neil Boyer

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** Single

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

7. Birth date of deceased April 28, 1945
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>16</u>	_____ hr. _____ min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Everett Boyer

13. Birthplace St. Genevieve Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mabel Hinni

15. Birthplace St. Genevieve Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Everett Boyer

(b) Address 8725 a Acacia

17. (a) Burial **(b) Date thereof** 5/14/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director 4600 Natural Bridge Ave

(b) Address Stroet - , Carroll Und Co

19. (a) MAY 14 1945 **(b)** _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis,

(c) City or town Jennings
(If outside city or town limits, write "RURAL")

(d) Street No. 8725 a Acacia
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14
year 1945 hour 7 minute a M.

21. I hereby certify that I attended the deceased from Apr 27, 1945 to May 14, 1945
that I last saw him alive on May 7, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Renal uremia

Due to 7 1/2 months diet

Due to digest food

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

Major findings: 159

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? _____

23. Signature W. H. [unclear]
(Specify type of place) (M. D. or other)

Address 803 N. [unclear] **Date signed** 5-14-45

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, fact should be so stated above.