

**FILED** OCT 4 1945

Registration District No. ....

Primary Registration District No. **1000**

Registrar's No. **972**

1. PLACE OF DEATH:

(a) County **Buchanan**  
(b) City or town **St. Joseph**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Mo. Methodist Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **14 days**  
(Specify whether  
In this community **2 years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan** //  
(c) City or town **St. Joseph** /  
(If outside city or town limits, write "RURAL")  
(d) Street No. **619 North 17th** 7  
(If rural, give location)  
(e) Citizen of foreign country? **no** 6 (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **William Lewis Boyles**

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 **widowed**

6. (b) Name of husband or wife **Mary K. Boyles** 6. (c) Age of husband or wife if alive **6th** years

7. Birth date of deceased **May 6th 1861**  
(Month) (Day) (Year)

8. AGE: Years **84** Months **4** Days **5** If less than one day hr. min.

9. Birthplace **Andrew County Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **retired farmer**

11. Industry or business

12. Name **Martin Boyles**

13. Birthplace **Andrew Co. Missouri**  
(City, town, or county) (State or foreign country)

14. Maiden name **Evelyn Lewis**

15. Birthplace **Andrew Co. Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Neele B. Thomas**

(b) Address **619 North 17th**

17. (a) **removal** (b) Date thereof **9/11/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fowler, Colo.**

18. (a) Signature of funeral director **Walter Beale & Bowman**

(b) Address **319 So. 10th**

19. (a) **9/11/45** (b) **AD Hestlebach**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **11th**  
year **1945** hour **8** minute **05 A.M.**

21. I hereby certify that I attended the deceased from **8/26 - 45** to **9/11**, 19**45**  
that I last saw him alive on **9/10 - 1945**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Fracture of hip (r)** Duration **16 days**

Due to

Due to

Other conditions **attend. selegis? 4yr**  
(Include pregnancy within 3 months of death) **(see) 5 days**

Major findings: **Fracture of r. hip (inter-trochanteric)**

Of operations

Of autopsy **none**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **accident** 131

(b) Date of occurrence **8/26/45**

(c) Where did injury occur? **St. Joseph, Buch., Mo.**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**In private nursing home**  
(Specify type of place)

While at work? **no** (e) Means of injury **Fall on floor**

23. Signature **G. T. Thomas** (M. D. or N. D.)

Address **1218 N. 32 St.** Date signed **9/11/45**

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

MOTHER FATHER

1428

2-1333

Dr. H J Bloomer  
1218 N. 3rd



**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 *Frank A. Bloomer*

Licensed Embalmer No. 1710

P. O. Address *St. Joseph 24*

**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.