No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 2 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29977

Registration District No. 517 — Primary Registration District No. 3069 — Registrar's No. 1887

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Clayton, Missouri Richmond Hts
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's 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 .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Illinois (b) County: St. Clair 999
(c) City or town: Marissa 11
(If outside city or town limits, write "RURAL.") 0
(d) Street No. 2
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Samuel Stanley 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: Widowed
6. (b) Name of husband or wife: Martha E. Boyle
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: June (Month) 7 (Day) 1865 (Year)

8. AGE: Years 82 | Months 2 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace: Marissa (City, town, or county) Illinois (State or foreign country)
10. Usual occupation: Retired Merchant
11. Industry or business .....

FATHER
12. Name: Samuel Boyle
13. Birthplace: Randolph County (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name: Elizabeth E. Thompson
15. Birthplace: Marissa (City, town, or county) Illinois (State or foreign country)

16. (a) Informant: Dr. Clyde K. Boyle
(b) Address: Euclid at Delmar Blvd.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 8/25/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Marissa, Illinois
18. (a) Signature of funeral director: Albert H. Hoppe
(b) Address: 4700 Washington Blvd.
19. (a) 8-25-47 (Date received local registrar) (b) Carla [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25 year 1947 hour 7 minute 50 A.M.
21. I hereby certify that I attended the deceased from Aug 20, 1947 to Aug 25, 1947; that I last saw him alive on Aug 24, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of Prostate	6 mo +
Due to: 5 lb	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Metastases of Ca to liver + abdomen	6 mo +
Major findings: Of operations:	
Of autopsy: as above.	

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: 0

23. Signature: P. Amezera (M. D. or other)
Address: 539 N. Grand Date signed: 8/25/47

(Licensed Embalmer's Statement on Reverse Side)

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.