

FILED DEC 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38542

State File No. _____

318

1003

Registrar's No. 10046

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before administration). a. STATE <u>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u>)		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>1072 Melvin Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1072 Melvin Ave.</u>				d. STREET ADDRESS (If rural, give location) <u>1072 Melvin Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Gonstance</u>		b. (Middle) <u>Jean</u>		c. (Last) <u>Boyd</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 20 1949</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>(11)</u>		8. DATE OF BIRTH <u>Mar. 15 1947</u>	
9. AGE (In years last birthday) <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <u>Gene Boyd</u>		13b. MOTHER'S MAIDEN NAME <u>Florence Boyd</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Gene Boyd, 1072 Melvin Ave.</u> ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tumor of Brain</u> ANTECEDENT CAUSES <u>Cerebellar Pontine Area</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis Mo.</u>		21f. HOW DID INJURY OCCUR? <u>23X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>9-22, 1949</u> , to <u>11-20, 1949</u> , that I last saw the deceased alive on <u>11/24, 1949</u> and that death occurred at <u>10 P m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>J. D. Basater</u> (Degree or title) _____		23b. ADDRESS <u>5899 Delmar</u>		23c. DATE SIGNED <u>11/21/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>11-23-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>NOV 22 1949</u>		REGISTRAR'S SIGNATURE <u>J. D. Basater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Drehmann-Harral, 1905 Union Blvd.</u> ADDRESS _____			

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

Brain tumor

X

5899 Delmar Blvd.
(2-5)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed Warren A. Carter

Licensed Embalmer No. 3534

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.