

FILED DEC 1 1951

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State File No.

Registrar's No.

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 admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 1700 Newstead			
3. NAME OF DECEASED (Type or Print) Magnolia		a. (First)		b. (Middle)		c. (Last) Boykins	
4. DATE OF DEATH Nov. 19 1951		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Whit		9. AGE (In years last birthday) 65	
5. SEX Female		6. COLOR OR RACE Colored		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Calvin Mitchell		13b. MOTHER'S MAIDEN NAME Mary	
14. NAME OF HUSBAND OR WIFE Joseph Boykins		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Joseph Boykins 1700 N. Newstead	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Tuberculous Meningitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Tuberculosis DUE TO (c) Undetermined II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. No				INTERVAL BETWEEN ONSET AND DEATH Undet.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? PO 2X					
22. I hereby certify that I attended the deceased from 11-15, 19 51 to 11-19, 19 51, that I last saw the deceased slide on 11-19, 1951, and that death occurred at 11:35pm., from the causes and on the date stated above.							
23a. SIGNATURE Dorena W. Harris, M.D.				23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 11-20-51	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Nov 24/51		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL OFFICE NOV 23 1951		REGISTRAR'S SIGNATURE Carl Smith, M.D. R.P.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. W. Green 4214 Delmar			

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

**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

*J. C. Green*

Licensed Embalmer No.

*2963*

P. O. Address

*4214 Selman*

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.