

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **15496**
4226
Registrar's No.BIRTH NO. **31555** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (in this place) 3 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity		d. STREET ADDRESS (If rural, give location) 3907 Kirtpatrick Homes	
3. NAME OF DECEASED (Type or Print) a. (First) KATHLEEN b. (Middle) ELAINE c. (Last) Boyett			4. DATE OF DEATH (Month) (Day) (Year) April 23 1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) --	8. DATE OF BIRTH April 20 1953
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY --	12. CITIZEN OF WHAT COUNTRY? --
13a. FATHER'S NAME Homer Macon Boyett		13b. MOTHER'S MAIDEN NAME Grace Leone English	14. NAME OF HUSBAND OR WIFE --
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. **	17. INFORMANT'S SIGNATURE OR NAME Homer & Grace Boyett
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Kernicterus INTERVAL BETWEEN ONSET AND DEATH 4 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Erythroblastosis Fetalis 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	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 7701	
22. I hereby certify that I attended the deceased from April 20, 1953 to April 23, 1953 that I last saw the deceased alive on April 23, 1953 , and that death occurred at 8:35 P. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) C. J. Vannellon M.D.		23b. ADDRESS 630 S. Kingshighway Blvd	
23c. DATE SIGNED 4-24-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 4-27-53	
24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		24d. LOCATION (City, town, or county) (State) GRANITE CITY ILL.	
DATE REC'D BY LOCAL REG. APR 24 1953		REGISTRAR'S SIGNATURE J. C. Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Henry J. Bryan		ADDRESS GRANITE CITY, ILL.	

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 _____

NOT EMBALMED

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Henry J. Pieper*

Licensed Embalmer No. _____

P. O. Address *Granite City, Ill.*

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.