

FILED MAR 30 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2599

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Mo</u> b. COUNTY <u>Franklin</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (In this place) <u>2 hrs</u>		c. CITY OR TOWN <u>St. Clair</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Baptist Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>0309</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Harry</u>		b. (Middle) <u>Frank</u>	
		c. (Last) <u>Boyster Jr</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 19 1954</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	
8. DATE OF BIRTH <u>August 19 1940</u>		9. AGE (In years last birthday) <u>13</u>		10. IF UNDER 1 YEAR Days <u>7</u> IF UNDER 12 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school boy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>school boy</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Gerster Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Harry Boyster</u>		13b. MOTHER'S MAIDEN NAME <u>Olive Gibson</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>496-38-0684</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Harry F Boyster</u>		ADDRESS <u>St Clair Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Rheumatic Heart Disease</u>			
		ANTECEDENT CAUSES			
		DUE TO (b) <u>Acute Rheumatic Fever</u> 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, 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? _____ <u>4013</u>	
22. I hereby certify that I attended the deceased from <u>3-19-1954</u> , to <u>3-19-1954</u> , that I last saw the deceased alive on <u>3-19-1954</u> , and that death occurred at <u>9:40 P</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Joseph E. Conroy M.D.</u>		(Degree or title)		23b. ADDRESS <u>906 Olive St</u>	
23c. DATE SIGNED <u>3-20-54</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>March 17 1954</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>odd fellow Cem</u>		24d. LOCATION (City, town, or county) (State) <u>St. Clair, Missouri.</u>			
DATE REC'D BY LOCAL REG. <u>MAR 22 1954</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sherwood E. Mitchell</u> ADDRESS <u>St. Clair, Mo.</u>	

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

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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.....  
Signature of Student Embalmer

Signed *Sherwood W. Mitchell*

Licensed Embalmer No. *38*

P. O. Address *St. Clair*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.