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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19897

State File No. \_\_\_\_\_

FILED JUN 27 1955

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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 <b>Missouri</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>4736 Alabama</b>				
3. NAME OF DECEASED (Type or Print)		a. (First) <b>LENA</b>		b. (Middle) <b>HELEN</b>		c. (Last) <b>BOYLE</b>		
4. DATE OF DEATH		(Month) <b>JUNE</b>		(Day) <b>11</b>		(Year) <b>1955</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>March 16, 1895</b>		
9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13a. FATHER'S NAME <b>William Bojtas</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Semelroth</b>		14. NAME OF HUSBAND OR WIFE <b>William G. Boyle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <b>487-36-7071</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Ruth Austin, 5627a So. Kingshighway</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Subarachnoid hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH _____		
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
11. 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 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 _____ <b>330x</b>				
22. I hereby certify that I attended the deceased from <b>6-5-55</b> , 19____, to <b>6-11-55</b> , 19____, that I last saw the deceased alive on <b>6-11-55</b> , 19____, and that death occurred at <b>1:55A m.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>Le B. Smith MD</b> (Degree or title) _____				23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>6-13-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>6-13-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>		
DATE REC'D BY LOCAL REG. <b>JUN 13 1955</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington Blvd.</b>				

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

(Licensed Embalmer's Statement on Reverse Side)

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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..... *Erna R. Cadwell*

Licensed Embalmer No. *407*

P. O. Address *St. Louis*

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.