

FILED MAY 25 1956

STANDARD CERTIFICATE OF DEATH

State File No. 17592

BIRTH NO. 26627-56 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4084

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity (If not in hospital or institution, give street address or location)		d. STREET ADDRESS (If rural, give location) 4102a Lexington Avenue	
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Boland		4. DATE OF DEATH (Month) (Day) (Year) April 14 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ---	8. DATE OF BIRTH April 9 1956
9. AGE (In years last birthday) 5		10. UNDER 1 YEAR Months	10. UNDER 1 YEAR Days 5
10a. 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) St. Louis Missouri
12. CITIZEN OF WHAT COUNTRY? ---		13a. FATHER'S NAME James Claudia Boland	
13b. MOTHER'S MAIDEN NAME Myrl Louise Byers		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 Myrl Louise Boland		ADDRESS above	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity, length of gestation not compatible to date of birth. Circumvallate placenta. Due to (b) Marginal Sinus Rupture of Placenta. 7615	
INTERVAL BETWEEN ONSET AND DEATH 5 hrs.		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"/>		7615	
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) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 9 1956, to April 14, 1956, that I last saw the deceased alive on April 14, 1956, and that death occurred at 9:50 A.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Dr. Ballen M.D.		23b. ADDRESS 9630 S. Kingshighway	
23c. DATE SIGNED 4-23-56		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 4-30-56		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland - aka 4104 Manchester	
DATE REC'D BY LOCAL REG. APR 25 1956		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.