

FILED JUN 11 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17607

State File No.

318

1003

Registrar's No. 4302

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 4302		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____ Mo St. Louis				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN _____		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN _____		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				e. STREET ADDRESS (If rural, give location) _____				
BARNES HOSPITAL				6800 Edison				
3. NAME OF DECEASED (Type or Print) a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) _____					
Clarence E. Boyles			May 1, 1956					
5. SEX _____		6. COLOR OR RACE _____		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____		8. DATE OF BIRTH _____		
M		W		Married		Sept. 6, 1888		
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) _____		12. CITIZEN OF WHAT COUNTRY? _____	
67yrs			Purchasing Agent Gaylord Cont. Co.		Hillview, Ill.		USA	
13a. FATHER'S NAME _____			13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE _____			
Barton W. Boyles			Nancy Jane Featherston		Augusta Tess Boyles			
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 _____ ADDRESS _____			
No			None		Mrs. Augusta Boyles 6800 Edison			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) _____				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH _____
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____				Cerebrovascular Accident				Yrs. _____
*This does not mean the mode of dying, such as heart failure, ashenia, 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.				Yrs. _____
DUE TO (b) _____				Cerebral arteriosclerosis				Yrs. _____
DUE TO (c) _____				331 XH				Yrs. _____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				Carcinoma of larynx with metastases				5 mos. ?
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
4/25/56		Findings Carcinoma of larynx Laryngoscopy & left radical neck dissection						
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? _____				
22. I hereby certify that I attended the deceased from _____ April 19, 19 56, to _____ May 1, 19 56, that I last saw the deceased alive on _____ May 1, 19 56, and that death occurred at _____ 6:00A m., from the causes and on the date stated above.								
23a. SIGNATURE _____ (Degree or title) _____				23b. ADDRESS _____		23c. DATE SIGNED _____		
FR Bradley M. D.				BARNES HOSPITAL		5/1/56		
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE _____		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) _____		
Removal		May 3, 1956		White Hall Cemetery		White Hall, Ill.		
DATE REC'D BY LOCAL REG. _____		REGISTRAR'S SIGNATURE _____		25. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____				
MAY 1 1956		J. Carl Smith		6175 Delmar				

(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 James H. Anderson, Student Embalmer No. 20 working under my personal supervision.

Student James H. Anderson
Signature of Student Embalmer

Signed Jos. E. McCulloch

Licensed Embalmer No. 246

P. O. Address 617026

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.