

FILED FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6022

State File No. 1003  
Registrar's No. 1140

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 1003		Registrar's No. 1140	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Washington					
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis			c. LENGTH OF STAY (in this place)		c. CITY OR TOWN Union Township		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John Hospital				e. STREET ADDRESS (If rural, give location) 1100 37 Cadet, Mo. RR #1					
3. NAME OF DECEASED (Type or Print)		a. (First) Mary		b. (Middle) Elizabeth		c. (Last) Boyer		4. DATE OF DEATH (Month) (Day) (Year) Feb. 2 1957	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Nov. 1. 1877		9. AGE (In years last birthday) 79 IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and State or Foreign Country) Washington, Co., Mo.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Pascal De Clue			13b. MOTHER'S MAIDEN NAME Mary Coleman			14. NAME OF HUSBAND OR WIFE John L. Boyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Peter A. Boyer Potosi, Missouri					
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral palsy</i>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Cerebral thrombosis</i> DUE TO (c) <i>Arteriosclerosis</i>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 332*						INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
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) m.		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 <i>Jan</i> , 1954, to <i>2-2-</i> , 1957, that I last saw the deceased alive on <i>2-2-</i> , 1957, and that death occurred at <i>6 P. M.</i> , from the causes and on the date stated above.									
23a. SIGNATURE <i>Carl J. Rex</i>				23b. ADDRESS <i>188 Kings highway</i>				23c. DATE SIGNED <i>2-4-57</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE <i>2-5-1957</i>		24c. NAME OF CEMETERY OR CREMATORY <i>St. Joachims</i>		24d. LOCATION (City, town, or county) (State) <i>Old Mines, Missouri</i>			
DATE REC'D BY LOCAL REG. FEB 4 '57		REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Arthur H. Smith Potosi Mo.</i>				

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

(Licensed Embalmer's Statement on Reverse Side)

**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 *Samuel B. Stetler* .....

Licensed Embalmer No. *4109*

P. O. Address *Laurel* .....

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.