

1. Health,
& Welfare
5. Public
Health Service

5. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 26 1957

14495

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's

3506

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jefferson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN Herculaneum | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital | | d. STREET ADDRESS (If outside, give location) 531 Hill Street | |
| 3. NAME OF DECEASED (Type or print) James Boyer | | 4. DATE OF DEATH April 9 1957 | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 1, 1898 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman | | 11. BIRTHPLACE (City and state or country) Suldivan, Missouri | |
| 13. FATHER'S NAME Thomas Boyer | | 14. MOTHER'S MAIDEN NAME Mary Pruitt | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 493-07-5488 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio-sclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 420.0 | |
| 20c. TIME OF INJURY a. m. p. m. | | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from 8:55/10/22/56, to 4/9/57 and last saw her alive on 4/9/57 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) Edward W. Gabinski MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE April 12, 1957 | |
| 23c. NAME OF CEMETERY OR CREMATORY Roselawn Memorial | | 23d. LOCATION (City, town, or county) (State) Crystal City, Missouri | |
| 24. FUNERAL DIRECTOR Vinyard Fun'l Homes, Inc., Festus, Mo | | 25. DATE RECD. BY LOCAL REG. APR 12 '57 | |
| 26. REGISTRAR'S SIGNATURE J. C. Smith MD | | 27. DATE SIGNED 4/10/56 | |

(Licensed Embalmer's Statement on Reverse Side)

MAR 14 1958

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.....
Heath B. V. [Signature]

Licensed Embalmer No. 497

P. O. Address *Festus*

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.