FILED APR 20 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014725
State File No.

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. 2 3251

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2530 N. GARRISON

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
d. STREET ADDRESS (If rural, give location): 2530 N. GARRISON

3. NAME OF DECEASED (Type or Print): a. (First) MORGAN b. (Middle) BOYINGTON c. (Last)
4. DATE OF DEATH (Month) 3 (Day) 26 (Year) 59
5. SEX: MALE
6. COLOR OR RACE: COLORED
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: UNKNOWN
9. AGE (In years last birthday): 76 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): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): UNKNOWN
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: UNKNOWN
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE: ROSIE LEE BOYINGTON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Beatrice Welch ADDRESS: 2562 Glasgow Ave.

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Senility

DUE TO (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

420.0

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 12:30 P. m., from the causes and on the date stated above.*

23a. SIGNATURE: Paul J. Simon Deputy Coroner (Degree or title)
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 4/1/59

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 4-1-59
24c. NAME OF CEMETERY OR CREMATORY: FATHER DICKSON CEM.
24d. LOCATION (City, town, or county) (State): ST. LOUIS COUNTY, MO.

DATE REC'D BY LOCAL REG.: APR 1 '59
REGISTRAR'S SIGNATURE: Joan Smith, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE: McCLAIN ADDRESS: 4231 WASHINGTON

(Licensed Embalmer's Statement on Reverse Side)

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

No. Embalming

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 .....
Student Embalmer

Signed Oscar McClain

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.