

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014726
STATE FILE NUMBER
2 3244

FILED APR 20 1959 Registration District No. Primary Registration District No. Registrar No.

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ANATOMICAL
MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		c. CITY OR TOWN <u>St. Louis, Missouri</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis State Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>5400 Arsenal St.,</u>	
Length of stay in lbs. <u>over 20 yrs.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>BOYLES</u> Last <u>BOYLES</u>			4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1903</u>
9. AGE (In years last birthday) <u>56</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Jefferson City, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Rufus Puckett</u>	
13b. MOTHER'S MAIDEN NAME <u>Belle Clark</u>		14. NAME OF HUSBAND OR WIFE <u>John Boyles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>Hospital Records 5400 Arsenal</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Post-Cholecystectomy - 36 hours</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>March 29, 1937</u> to <u>March 13, 1959</u> and last saw her <u>alive</u> on <u>March 13, 1959</u> Death occurred at <u>9:15</u> P.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. Joe Martin, M.D.</u>		22b. ADDRESS <u>5400 Arsenal St.</u>	22c. DATE SIGNED <u>3-14-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>3-31-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. <u>Rowland-Aker Mortuary Service</u> 4104 Manchester Ave. St. Louis 10, Mo.		25. DATE RECD. BY LOCAL REG. <u>MAR 31 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> <u>M D B</u>

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

Licensed Embalmer No.....

P. O. Address.....

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.