

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022554

STATE FILE NUMBER

FILED JUL 10 1959 Registration District No. 309 Primary Registration District No. 4050 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>ST. CHARLES</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>PORTAGE TOWNSHIP.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MISSISSIPPI RIVER NEAR ALTON ILL</b>		Length of stay in lb <b>VISIT</b>	d. STREET ADDRESS (If outside, give location) <b>3016 SAL</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>OLIVER RAY BOYER</b>			4. DATE OF DEATH Month Day Year <b>JUNE 21 1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 24, 1930</b>	9. AGE (In years last birthday) <b>29</b> IF UNDER 1 YEAR: Months <b>4</b> Days <b>28</b> IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SERVICE CO</b>	11. BIRTHPLACE (City and state or country) <b>EAST ST. LOUIS ILL</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>DENVER L. BOYER</b>		13b. MOTHER'S MAIDEN NAME <b>AMANDA HESS</b>	14. NAME OF HUSBAND OR WIFE <b>JEAN KASTING BOYER</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NONE</b>		16. SOCIAL SECURITY NO. <b>331-24-4749</b>	17. INFORMANT Address <b>JEAN BOYER, 3016 SALINA, ST. LOUIS, MO</b>		
18. CAUSE OF DEATH (None one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Swimming in River</b>			
		DUE TO (c) <b>9298</b>			
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 checked="" 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.) <b>Floating on innertube lost balance and Tube</b>		
20c. TIME OF INJURY Hour a.m. p.m. <b>June 22</b>		got away from him <b>092</b>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Mississippi River</b>	20f. CITY, TOWN, OR LOCATION <b>St. Charles</b>		STATE <b>Mo</b>
21. I attended the deceased from _____ to _____ and last saw her alive on _____ 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) <b>Marion M. Coroner</b>			22b. ADDRESS <b>Wentzville Mo,</b>		22c. DATE SIGNED <b>July, 6-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>JUNE 24, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PETERS</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY Mo.</b>
24. FUNERAL DIRECTOR <b>SCHNOR FUNERAL HOME, ST. LOUIS, Mo.</b>		ADDRESS <b>2125 LAFAYETTE</b>		25. DATE RECD. BY LOCAL REG. <b>JUNE 22-59</b>	26. REGISTRAR'S SIGNATURE <b>Dates Recd. JK King</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 *Howard O Kessler*

Licensed Embalmer No. *4631*  
P. O. Address. *Wentzville, Mo*

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.