RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–030263
STATE FILE NUMBER

FILED VS AUG 18 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2-7275

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis,
Length of stay in 1b: 9 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St.Louis-Little Rock Hospitals, Inc.,
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jefferson
c. CITY OR TOWN: De Soto,
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 409 East Main St.,
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Adam Middle: Joseph Last: Boyer
4. DATE OF DEATH: Month: August Day: 3, Year: 1959.
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: April 14, 1899
9. AGE (last birthday): 60 yrs.
IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HR: Hours ____ Min. ____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (City and state or country): Old Mines, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Lucian Boyer
13b. MOTHER'S MAIDEN NAME: Dora Thebeau
14. NAME OF HUSBAND OR WIFE: Julia Boyer
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.: 702-14-7248
17. INFORMANT: Joseph Boyer Address: DeSoto, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Appendicitis, acute — 9 days
DUE TO (c): 550.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Cirrhosis of Liver
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 WORK ☐ NOT WHILE AT WORK ☐
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 7/26/59, to 8/3/59, and last saw her/him alive on 8/3/59.
Death occurred at 10:30 P.M., m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: H Pennington MD (Degree or title)
22b. ADDRESS: 1755 South Grand Blvd.,
22c. DATE SIGNED: 8-4-59
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8/6/59
23c. NAME OF CEMETERY OR CREMATORY: Calvary
23d. LOCATION (City, town, or county) (State): DeSoto Mo.
24. FUNERAL DIRECTOR: Mothershead Mortuary ADDRESS: De Soto, Missouri
25. DATE RECD. BY LOCAL REG.: AUG 5 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

AUG 25 1959

AUG 24 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Andrew H. England

Licensed Embalmer No. 4745

P. O. Address De Soto, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.