

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 12/62** STATE FILE NUMBER **59-046943**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1 mo		c. CITY OR TOWN St. Ferdinand Twp		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2137 Greenslope		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERMINE Middle K. Last BOYER				4. DATE OF DEATH Month December Day 30th , Year 1959			
5. SEX female	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 10/20/90	9. AGE (last birthday) 69	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) retired teacher		10b. KIND OF BUSINESS OR INDUSTRY Elementary School		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Gustav F. Keller		13b. MOTHER'S MAIDEN NAME Kunigundi Landerer		14. NAME OF HUSBAND OR WIFE Grover A. Boyer			
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. 495-42-0105	17. INFORMANT Address Grover A. Boyer, 2137 Greenslope Dr				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary edema pancreatic carcinoma DUE TO (b) pancreatic carcinoma DUE TO (c) 157x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 6 days 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <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 11-25-59 to 12-29-59 and last saw her alive on 12-24-59 Death occurred at 8:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE W. A. King (Degree or title)			22b. ADDRESS 8201 N Broadway			22c. DATE SIGNED 2/31/59 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 1/2/60	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		23d. LOCATION (City, town, or county) St. Louis, Mo.			
24. FUNERAL DIRECTOR Emil J. Heitzenroeder, 8319 Hallsferry ADDRESS				25. DATE RECD. BY LOCAL REG. DEC. 31-1959		26. REGISTRAR'S SIGNATURE Leon Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

3.P.

2187

STATE OF MISSOURI

DEPARTMENT OF HEALTH

CERTIFICATE OF

EMBALMENT

NO. _____

DATE _____

BY _____

OF _____

CITY _____

TO _____

DECEASED _____

TRUSTEES OF _____

TO BE _____

EMBALMED BY _____

AT _____

IN _____

STATE OF _____

ON _____

STATEMENT BY LICENSED EMBALMER

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

_____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Elton H. Remelick

Licensed Embalmer No. 4283

P. O. Address St. Louis

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