

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028140

FILED VS. JUL 22 1960

318

1003

6767

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Wood Hospital		d. STREET ADDRESS (If outside, give location) 1616 McPherson, Ave.	

3. NAME OF DECEASED (Type or print) First Earl Middle Last Boyer			4. DATE OF DEATH Month July Day 2 Year 1960		
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5. SEX Male	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 9/22/1896	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Rooming House Operator	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) McLeansboro, Illinois.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Unknown Boyer	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Irene
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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. None	17. INFORMANT Irene Boyer, 1616 McPherson, Ave.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Coronary Occlusion Posterior Coronary Infarction Hypertrophy of Ventricles 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) Pulmonary Infarction		INTERVAL BETWEEN ONSET AND DEATH ?
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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.) 4201
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

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 7/2/60	COUNTY	STATE
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21. I attended the deceased from 4/18/54 to 7/2/60 and last saw him alive on 7/1/60 . Death occurred at 5:30 am 7/2/60 on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE George W. Mikhael MD	22b. ADDRESS 3903 Olivoz	22c. DATE SIGNED 7/5/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-5-60	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) Belleville, Illinois.
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24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. JUL 4 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MBE

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 _____

Melvin L. Kemper

Licensed Embalmer No. 4052

P. O. Address 11411 Wash

St Louis

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