

REC'D OCT 12 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
100830447
Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City *St. Louis*..... (d) Street No. *3624 Hickory*..... Registered No. *7884*
(e) Length of residence in city or town where death occurred yrs. *7* mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. *3624 Hickory* St. *18* (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mary K. Boyer*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 12-1871*
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
67 4 24

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) *Aug. 1937*
11. Total time (years) spent in this occupation *45 yrs*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown Michigan*

FATHER 13. NAME *Charles E. Boyer*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown Unknown*

MOTHER 15. MAIDEN NAME *Anna Unknown*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *" "*

17. INFORMANT (ADDRESS) *Mrs. J. Williams 3624 Hickory, St.*18. BURIAL, CREMATION, OR REMOVAL PLACES *Festus, Mo.* DATE *Sept. 10, 38*19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Albert H. Hoppe, Inc. 429 N. Euclid Ave.*20. FILED *J. D. Bridges Local Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept. 6 - 1938*

22. I HEREBY CERTIFY, That I attended deceased from *Aug. 30*, 1938, to *Sept. 6*, 1938
I last saw him alive on *on 8-24-38*, 1938. Death is said to have occurred on the date stated above, at *9:45 A.*
The principal cause of death and related causes of importance were as follows:

*Chronic myocarditis*Date of onset
1-1-1938

Other contributory causes of importance:

Severe attack pneumonia in Jan. last.

Name of operation..... Date of.....

What test confirmed diagnosis? *Clinical* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.Manner of injury.....
Nature of injury.....24. Was disease or injury in any way related to occupation of deceased? *no.*

If so, specify

(Signed) *Orrick E. Smith, M. D.*(Address) *4103 W. Pine*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Registered Apprentice No., working under my personal supervision.

Signed.....

J. G. Sullivan

Licensed Embalmer No. *1122*

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 this body is not embalmed, above space should be left blank.