

1939 MAY 10 1939

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

791
1003
12961
Do not use this space.

1. PLACE OF DEATH

(a) County *St. Louis* Registration District No. *791*
 (b) Township *St. Louis* Primary Registration District No. *1003*
 (c) City *St. Louis* (d) Street No. *Park Lane Memorial Hosp.* St. Registered No. *3303*
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. *6070 Cates Ave* St. *5*
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Wh* 5. SINGLE, MARRIED, WIDWED, OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov. 30, 1902*

7. AGE YEARS *36* MONTHS *4* DAYS *7* If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Private Secretary*
 9. Industry or business in which work was done, as saw mill, bank, etc. *Wagner Elec. Co.*
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Hillsboro Mo*

FATHER 13. NAME *Joseph Boyer*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

MOTHER 15. MAIDEN NAME *Clara Huskey*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Morse Mill Missouri*

17. INFORMANT (ADDRESS) *Bertrude Boyer 6070 Cates*

18. BURIAL, CREMATION, OR REMOVAL *Hillsboro Mo* DATE *Apr. 10, 1939*

19. FUNERAL DIRECTOR (ADDRESS) *Wm. T. Martin 1725 Mission Blvd*

20. FILED *APR 8 1939* *J. D. Butler* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 7, 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Mar 31, 1939* to *Apr 7, 1939*

I last saw her alive on *Apr 7, 1939*. Death is said to have occurred on the date stated above, at *11:30 P. m.*

The principal cause of death and related causes of importance were as follows:

Intestinal Obstruction
54

Other contributory causes of importance:

Serous Peritonitis
Green Strep. Bacterium

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

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? If so, specify

(Signed) *Dean J. Smith*, M. D.

(Address) *4930 Linnell Blvd.*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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, BERNARD H. J. STUART, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

..... L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed, Bernard H. J. Stuart

Licensed Embalmer No. 3500

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.)

1225 Union Blvd