

AUG 25 1940 791  
Registration District No.

Primary Registration District No. 1003

State File No.

Registrar's No. 6297

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: H G Phillins Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 mos 2 days  
Life (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis 22  
(If outside city or town limits write "RURAL")  
(d) Street No. 1020 a Chouteau  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24  
year 1940 hour 9:45 minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from  
April 22, 1940, to July 24, 1940,  
that I last saw her alive on July 24, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Bronchopneumonia  
Hydroureter  
Uterine Fibroid non Malignant

Duration  
10 days  
Indef

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Bronchopneumonia, Hydro-  
ureter, Uterine Fibroid

PHYSICIAN  
\_\_\_\_\_  
Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(If Means of injury \_\_\_\_\_)

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 2601 N Whittier Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME Ethel Bouyer 600

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security: No. Unemployed

4. Sex Female 5. Color or race old 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife Henry Bouyer 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased (Month) 1 (Day) 27 (Year) 1873

8. AGE: Years 67 Months 58 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business at home

12. Name Phillip Fairfax

13. Birthplace Missouri (City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Tex (City, town, or county) (State or foreign country)

16. (a) Informant Ida Croomes

(b) Address 1020 Chouteau

17. (a) Burial (b) Date thereof 7-27-40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director [Signature]

(b) Address 2906 Taylor

19. (a) JUL 27 1940 (b) J. F. Bredsch (Date of death) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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

working under my personal supervision.

*Raymond E. Gerke*, Registered Apprentice No. \_\_\_\_\_

Signed *Raymond E. Gerke*  
City license #281  
Licensed Embalmer No. 3985  
P. O. Address *St Louis, Mo*

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.

RECEIVED BY THE BOARD OF HEALTH - ST. LOUIS, MO

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 23852

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6297

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME

Ethel Boyer

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race Col  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
67 5 27 h. min.

9. Birthplace: (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace: (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 1-20-41 (b) J.F. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 24  
 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: (Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W.H. Donnelly (M. D. or other) \_\_\_\_\_

Address 2601 N. Wheelton signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTAL

