

No. 2
12-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 11 '47

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32349**
Registrar's No. **9266**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St Louis**
(b) City or town **St Louis**
(c) Name of hospital or institution: **Franklin St. Huber Hosp**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 weeks**
(Specify whether
In this community **40 yrs**
years, months or days)

3. (a) PRINT FULL NAME: **Walter James Boyle**

3. (b) If veteran, name war **nil** 3. (c) Social Security No. **?**

4. Sex **male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Rose** 6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **July 18 1879**
(Month) (Day) (Year)

8. AGE: Years **68** Months **2** Days **16** If less than one day hr. min.

9. Birthplace **Phil Penn**
(City, town, or county) (State or foreign country)

10. Usual occupation **Clerk**

11. Industry or business **Hotel**

12. Name **James Boyle**

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

14. Maiden name **unk**

15. Birthplace **unk** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Rose Boyle**

(b) Address **5603 Delmar**

17. (a) **Buried** (b) Date thereof **10-7-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem**

18. (a) Signature of funeral director **Ray Miller**

(b) Address **5041 Delmar**

19. (a) **OCT 6 1947** (b) **J. F. Briedeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **aaa**
(c) City or town **St Louis** **17**
(If outside city or town limits, write "RURAL") **9**
(d) Street No. **5603 Delmar** **0**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct 4** day **th**
year **1947** hour **7** minute **P.** M.

21. I hereby certify that I attended the deceased from **August 1947** 19 to **October 4** 19 **1947**
that I last saw him alive on **10/4** 19 **1947**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Thromb - post-operative** **2 wks**
post-operative
Due to **Paget's Disease Non-Tubercular**

Due to **Enlarged benign prostate** **5 yrs**

Other conditions: **unk**

Major findings: **Enlarged prostate**
Of operations
Of autopsy

Duration
Duration
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 **Carl W. Waterberg** (M. D. or other) **?**
Address **3720 Washington** Date signed **10/6/47**

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

W. P. Duphelle
Licensed Embalmer No. *3118*

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, fact should be so stated above.