

FILED AUG 7 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25693

BIRTH NO.		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6276		Registrar's No. 2562	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY St. Louis		c. LENGTH OF STAY (in this place) 136 days		a. STATE Mo.		b. COUNTY 8	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Koch (rural)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2259			
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital				d. STREET ADDRESS (If rural, give location) 100 N. Broadway 1			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
a. (First) William		b. (Middle)		c. (Last) Boyer		7 2 51	
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Div.		8. DATE OF BIRTH 9-10-98	
9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pipefitter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Benjamin Boyer		13b. MOTHER'S MAIDEN NAME Pearl McHood		14. NAME OF HUSBAND OR WIFE Jewel ??	
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. ??		17. INFORMANT'S SIGNATURE OR NAME Hospital Records, Koch Hosp, Koch, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 1 yr?	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pulmonary tuberculosis		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-16-51, 19___, to 7-2, 1951, that I last saw the deceased alive on 7-2, 1951, and that death occurred at 8:50 pm., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Robert R. Steen				23b. ADDRESS Koch Hosp, Koch, Mo.		23c. DATE SIGNED 7-3-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/5/51		24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. 7-3-51		REGISTRAR'S SIGNATURE Herbert R. Rombeck		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Fun. Dir. 2849 N. Euclid			

FEB 26 1956

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Robert L. Brinkman

Licensed Embalmer No. 3553

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.