

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21770**
Registrar's No. **5344**

FILED JUN 27 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Washington		
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) 1 da.	c. CITY (If outside corporate limits, write RURAL and give township) Tiff		1100
d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda Hospital			d. STREET ADDRESS (If rural, give location) Gen'l Delivery		
3. NAME OF DECEASED (Type or Print) a. (First) Lulu b. (Middle) Augustine c. (Last) Boyer			4. DATE OF DEATH (Month) (Day) (Year) June 10, 1952		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Nov. 15, 1875	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and State or Foreign Country) Washington County, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Simon Boyer		13b. MOTHER'S MAIDEN NAME Rith Marler	14. NAME OF HUSBAND OR WIFE Samuel Boyer		
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. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Earl Boyer Tiff, 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular Heartdisease Cerebral Hemorrhage DUE TO (b) arteriosclerosis cerebral DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 16 hours yes
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) St. Louis, Mo.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X		
22. I hereby certify that I attended the deceased from 6/9/52, 19 , to 6/10/52, 19 , that I last saw the deceased alive on 6/10/52, 19 , and that death occurred at 12:24 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) R. Arnera M.D.		23b. ADDRESS 539 N. Grand		23c. DATE SIGNED 6/10/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/13/52	24c. NAME OF CEMETERY OR CREMATORY St. James	24d. LOCATION (City, town, or county) (State) Potosi, Mo.		
DATE REC'D BY LOCAL HEALTH DEPT. JUN 11 1952	REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. Lee Mothershead DeSoto, Mo.		

(Licensed Embalmer's Statement on Reverse Side)

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

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 Andrew H. England

Licensed Embalmer No. 4745

P. O. Address De Soto, 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, fact should be so stated above.