

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5938

State File No. _____

FILED MAR 4 1954

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1248

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) ST. LOUIS, MISSOURI		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Salem
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) MYRTLE b. (Middle) E. c. (Last) BOLES		4. DATE OF DEATH (Month) (Day) (Year) February 6, 1954	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 10-5-1923
9. AGE (In years last birthday) 30	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) Marion Co., Ill.
12. CITIZEN OF WHAT COUNTRY? USA	13a. FATHER'S NAME Joseph C. Boles	13b. MOTHER'S MAIDEN NAME Ethel Smith	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hosp. Records	
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) Questionable cardiovascular accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Tetralogy of Fallot DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 2/5/54		19b. MAJOR FINDINGS OF OPERATION Tetralogy of Fallot	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)	21f. HOW DID INJURY OCCUR? 331x
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from 1-23-1954, to 2-6-1954, that I last saw the deceased alive on 2-6-1954, and that death occurred at 5:15 a.m., from the causes and on the date stated above.			
23a. SIGNATURE <i>E. P. Smith M.D.</i>		23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 2-6-54
24a. BURIAL, CREMATION, REMOVAL removal	24b. DATE 2-7-54	24c. NAME OF CEMETERY OR CREMATORY -	24d. LOCATION (City, town, or county) (State) Salem, Ill.
DATE REC'D BY LOCAL REG. FEB 9 1954	REGISTRAR'S SIGNATURE <i>J. Earl Smith M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hancock F.H., Salem, Ill.	

S.P. (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.....
Signature of Student Embalmer

Signed.....
B. H. Hoffmann

Licensed Embalmer No.....
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P. O. Address.....
H. L.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.