

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6011

State File No.

BIRTH NO. 10131-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1457

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place)

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity 0

d. STREET ADDRESS (If rural, give location) 3945 Mc Pherson Avenue

3. NAME OF DECEASED
a. (First) b. (Middle) c. (Last)
Boler

4. DATE OF DEATH (Month) (Day) (Year)
February 2 1955

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ---

8. DATE OF BIRTH February 2 1955 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 2 WKS. Hours Mins. 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --- 10b. KIND OF BUSINESS OR INDUSTRY --- 11. BIRTHPLACE (State or foreign country) St. Louis Missouri 12. CITIZEN OF WHAT COUNTRY? ---

13a. FATHER'S NAME William Boler 13b. MOTHER'S MAIDEN NAME Ruth Cecelia Greene 14. NAME OF HUSBAND OR WIFE ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --- 16. SOCIAL SECURITY NO. --- 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ruth & William Boler above

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prognosis of umbil. cord.

ANTECEDENT CAUSES
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Breech presentation

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

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR 7610

22. I hereby certify that I attended the deceased from Feb 2, 19 55, to Feb 2, 19 55, that I last saw the deceased alive on Feb 2, 19 55 and that death occurred at 1:30 A., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank B. Long, M.D. 23b. ADDRESS 110 S. Central, Clayton 23c. DATE SIGNED 2/4/55

24a. BURIAL, CREMATION, REMOVAL (Specify) 24b. DATE 2-28-55 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. FEB 16 1955 REGISTRAR'S SIGNATURE J. Carl Smith MO 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary 4104 1/2 Manchester

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

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.