

FILED APR 27 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **13136**BIRTH NO. **25260-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2390**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Oreoland 427	
d. FULL NAME OF HOSPITAL OR INSTITUTION Evangelical Deaconess Hosp		d. STREET ADDRESS (If rural, give location) 8240 St. Charles Rock Rd.	
3. NAME OF DECEASED a. (First) Thomas b. (Middle) Wayne c. (Last) Boyer		4. DATE OF DEATH (Month) (Day) (Year) 3-15-55	
5. SEX Male	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 3-14-55
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) Missouri
13a. FATHER'S NAME Milton Wayne Boyer		13b. MOTHER'S MAIDEN NAME Dixie Ann Farris	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. M.W. Boyer ADDRESS 8240 St. Charles Rock Rd.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adolescentia		INTERVAL BETWEEN ONSET AND DEATH 42 hrs	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Prematurity (36 wk gestation)	
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	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	7625
22. I hereby certify that I attended the deceased from 3-14 , 19 55 , to 3-15 , 19 55 , that I last saw the deceased alive on 3-15 , 19 55 , and that death occurred at 8:00 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Carl Smith, Jr. M.D.		23b. ADDRESS 8505 Delwood Blvd.	23c. DATE SIGNED 3-16-55
24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 3-19-55	24c. NAME OF CEMETERY OR CREMATORY Mount Lebanon	24d. LOCATION (City, town, or county) (State) Pattonville Mo
DATE REC'D BY LOCAL REG. MAR 16 1955	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Carl Helgeson ADDRESS 4709 Oakland Oreoland Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

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.....

Earl J. Hellemann

Licensed Embalmer No. *3501*

P. O. Address.....

Greenland 14 N

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.