

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001817

STATE FILE NUMBER

FILED JAN 29 1959

Registration District No. 160 Primary Registration District No. 559V Registrar's No. 11

300
-57

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joachim Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Herculaneum</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>115 Curve St.</u>		Length of stay in lb <u>42 years</u>	d. STREET ADDRESS (If outside, give location) <u>115 Curve St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>NMN</u> Last <u>Boyer</u>	4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>1959</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1889</u>	9. AGE (In years last birthday) <u>69</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Leadworker (Ret)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>St. Joe Lead Co.</u>	11. BIRTHPLACE (City and state or country) <u>Potosi, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Simon Boyer</u>	13b. MOTHER'S MAIDEN NAME <u>Annie Gamble</u>	14. NAME OF HUSBAND OR WIFE <u>Maggie May Boyer</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>493-03-9308</u>	17. INFORMANT <u>Mrs. Maggie Boyer, Herculaneum, Mo.</u> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arterio sclerotic heart disease</u>	<u>5 yrs</u>
	DUE TO (c) <u>hypertension</u>	<u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u>8:20 A</u> Month <u>11</u> Day <u>18</u> Year <u>1959</u> a.m. <u>8:20 A</u> p.m.

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Herculaneum, Mo.</u>	COUNTY	STATE
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21. I attended the deceased from Death occurred at <u>11/18/59</u> to <u>11/18/59</u> and last saw him alive on <u>1/18/59</u> <u>8:20 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Dr. E. J. [Signature]</u> (Degree or title)	22b. ADDRESS <u>Herculaneum, Mo.</u>	22c. DATE SIGNED <u>1/19/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 21, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>Herculaneum, Mo.</u>
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24. FUNERAL DIRECTOR <u>Vinyard Fun'l Homes, Inc., Festus, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-19-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DATE
JAN 27 1959

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 Keith B. Vinson

Licensed Embalmer No. 4976
P. O. Address Festus, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.