

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014714
STATE FILE NUMBER
2786

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

MAY 1 1959

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY _____ | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. | | c. CITY OR TOWN ST. LOUIS, MO. | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP #1 | | d. STREET ADDRESS (If outside, give location) 2211 DICKSON | |
| Length of stay in lb _____ | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK BOLDEN | | | 4. DATE OF DEATH Month Day Year MARCH 12, 1959 |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/4/59 |
| 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 2 | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | 11. BIRTHPLACE (City and state or country) ST. LOUIS, MO. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME SAM BOLDEN | |
| 13b. MOTHER'S MAIDEN NAME DAISY GARNER | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none no | | 16. SOCIAL SECURITY NO. _____ | |
| 17. INFORMANT ST. LOUIS CITY HOSP. #1. | | Address _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Damage DUE TO (b) Shock - Post Operative DUE TO (c) Intestinal Obstruction - adhesions PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 570.5 |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 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.) | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | | |
| 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 _____ | | COUNTY _____ STATE _____ | |
| 21. I attended the deceased from 3/10/59 to 3/12/59 and last saw her alive on 3/12/59 Death occurred at 12:25 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Michael S. Boyer, MD. | | 22b. ADDRESS 1515 LAFAYETTE AVE. | |
| 22c. DATE SIGNED 3/12/59 | | 22d. (State) _____ | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 3-31-59 | | 23b. DATE _____ | |
| 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board | | 23d. LOCATION (City, town, or county) St. Louis, Mo. | |
| 23e. (State) _____ | | 23f. (State) _____ | |
| 24. FUNERAL DIRECTOR Rowland Aker 4104 Manchester | | 25. DATE RECD. BY LOCAL REG. MAR 19 '59 | |
| 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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

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