

**MRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS APR 22 1960**

**-60-016629**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **2 4068**

|   |  |   |   |   |   |  |  |
|---|--|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY _____                                |   |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST LOUIS, Mo</b>  |  |   | Length of stay in 1b _____  |   | c. CITY OR TOWN <b>ST. LOUIS</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>ST. LUKES HOSPITAL</b>  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>5045 S - 37th ST.</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BABY</b> Middle <b>BOYER</b> Last _____   |  |   |   | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>11</b> Year <b>60</b>   |   |  |  |
| 5. SEX<br><b>FEMALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>  |   | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>3-11-60</b>                                     |  |
| 9. AGE (last birthday)<br><b>29</b>   |  | IF UNDER 1 YEAR<br>Months _____ Days _____  |   | IF UNDER 24 HR<br>Hours _____ Min. <b>29</b>  |   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>_____  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>_____                                |   | 11. BIRTHPLACE (City and state or country)<br><b>ST LOUIS, Mo</b>         |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>                             |
| 13a. FATHER'S NAME<br><b>RONALD CRIDE BOYER</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>ALICE MARIE DESSEL</b>                    |   |   | 14. NAME OF HUSBAND OR WIFE<br>_____                                   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>_____   |  |   | 16. SOCIAL SECURITY NO.<br>_____  |   | 17. INFORMANT<br><b>MOTHER</b>  |  | Address<br><b>5045 S. 37th ST. ST LOUIS 16, Mo</b>                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary atelectasis</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Prematurity</b><br>DUE TO (c) <b>1 762.5</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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<br>Hour _____ a.m. _____ p.m.<br>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 <b>3-11-60</b> to <b>3-11-60</b> and last saw her/him alive on <b>3-11-60</b><br>Death occurred at <b>10:24 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |   |   |   |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>Bryce H. Bouchard M.D.</b>   |  |   |   | 22b. ADDRESS<br><b>950 Francis P. Clayton</b>   |   | 22c. DATE SIGNED<br><b>3-17-60</b>                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><b>4-30-60</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Anatomical Board</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Rowland Mortuary Svc. 4104-06 Manchester</b>   |  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>APR 14 1960</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b>                   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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.