

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

5131

-63-021359

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5131

FILED MAY 17 1963

VS 300 Rev. 4/59	DATE AMENDED
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79	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
	INSTEAD OF
	DOCUMENT
	MEDICAL CERTIFICATION
	SHOULD READ
	BY AFFIDAVIT OF
	ITEM NO.

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, give TOWNSHIP only) St. Louis, Missouri		Length of stay in 1b 10 mo.	c. CITY OR TOWN St. Louis
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Maternity		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6942 Winona Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last TIMOTHY M. Boyle			4. DATE OF DEATH Month Day Year 5 11 63
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-11-63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (last birthday) 10 25 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) St. Louis, MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James Francis Boyle		13b. MOTHER'S MAIDEN NAME Karna Sarah Meyer	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address JAMES BOYLE 6942 WINONA	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency & arrest DUE TO (b) Hypaline Membrane Disease / Newborn DUE TO (c) Premature birth Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 10 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 773.5			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 s.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 9:30 A.M. 5-11-63, to 7:55 P.M. 5-11-63 last saw him alive on 5-11-63. Death occurred at 7:55 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) Frederick D. Peterson MD		22b. ADDRESS 630 S. Kingshighway, St. Louis, Mo.	22c. DATE SIGNED 5-12-63
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 5-13-63	23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL CEMETERY	23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO
24. FUNERAL DIRECTOR HOWARD H. MICHAEL 5930 SOUTHWEST		25. DATE RECD. BY LOCAL REG. MAY 13 1963	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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

Not Embalmed
Howard H. Michel

Funeral Director

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.