

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0050977

318

1003

12813

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED JAN 16 1964

VS 300
Rev. 4/59

1

2 *224*

3

4 *0*

5 *2*

6

7 *0*

8 *2*

9

10

11

12 *91-3*

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		c. CITY OR TOWN <i>St. Louis</i>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Enroute to City Hosp</i>		d. STREET ADDRESS (If outside, give location) <i>3450 Indiana</i>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Ben</i> Middle Last <i>Boyer</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>25</i> Year <i>1963</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>8-9-1889</i>
9. AGE (last birthday) <i>74</i>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (City and state or country) <i>Missouri</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13a. FATHER'S NAME <i>John Boyer</i>		13b. MOTHER'S MAIDEN NAME <i>Ledwina, Gover</i>	
14. NAME OF HUSBAND OR WIFE <i>Anna</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Yes</i> (If yes, give war or dates of service) <i>World War I</i>		16. SOCIAL SECURITY NO. <i>Yes</i>	
17. INFORMANT <i>Beatrice Henderson, 3150 Oregon</i>		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) <i>Coronary occlusion</i> DUE TO (b) <i>Coronary Sclerosis</i> DUE TO (c) <i>4201</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 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 <i>4:30 P.</i> 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <i>4:30 P.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Helen L. Taylor, Coroner</i>		22b. ADDRESS <i>1300 Clark Ave.</i>	
22c. DATE SIGNED <i>12-26-63</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>12/30/63</i>	23c. NAME OF CEMETERY OR CREMATORY <i>National Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Jefferson Brk's., Mo.</i>
24. FUNERAL DIRECTOR <i>McLaughlin, 2301 Lafayette Ave.</i>		25. DATE RECD. BY LOCAL REG. <i>DEC 28 1963</i>	26. REGISTRAR'S SIGNATURE <i>Good Smith, M.D.</i>
St. Louis, Mo.			

1180300

1954

101

195

AL. 021177

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 James R. Chapman

Licensed Embalmer No. 4556

P. O. Address St. Louis 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.