

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

25927

1. PLACE OF DEATH

County..... Registration District No. **791** File No.
 Township..... Primary Registration District No. **1003** Registered No. **7543**
 City **St. Louis Mo.** (No. **City Hospital**) St. Ward)

2. FULL NAME

Delores Boedeker

(a) Residence. No. **2632^A Rutger** St. **22** Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **infant** (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov 7 - 1926**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 9 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Infant 186**
 (b) General nature of industry, business, or establishment in which employed (or employer) **194**
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Missouri**
 (STATE OR COUNTRY)

10. NAME OF FATHER **Wm Boedeker**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Mo.**
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Mellie Stanley**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Mo.**
 (STATE OR COUNTRY)

14. INFORMANT **Mr Wm Boedeker**
 (Address) **2632^A Rutger St**

15. FILED **AUG 24 1927** **Max B Starkloff**
 19..... REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug. 23 1927**

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at **6 a.** m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Shock & Injuries (Fracture Skull)
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) **Fall from Porch**
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **Accident**
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? **185**

WHAT TEST CONFIRMED DIAGNOSIS? **R. V. Via**

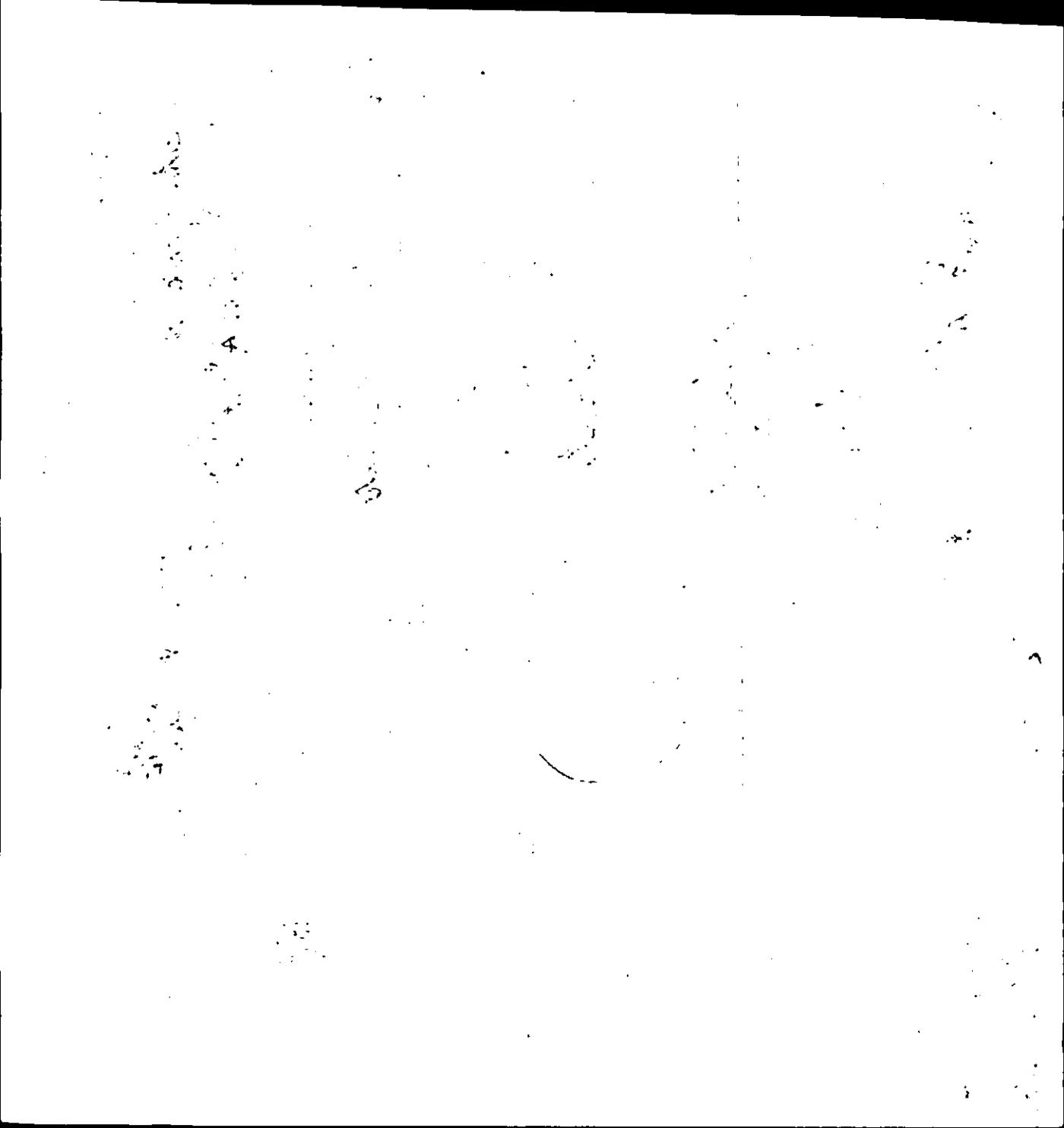
(Signed)..... M. D.

(Address) **24 Wm 19th Corcoran**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **St Johns Cemetery** DATE OF BURIAL **Aug. 24 1927**

20. UNDERTAKER **E. J. Schmur** ADDRESS **3125 Lafayette**



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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791 File No.....
Township..... Primary Registration District No. 1003 Registered No. 7573
City, St. Louis (No. St. Ward)

2. FULL NAME

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-7-1925

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 9 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED NOV-9 1927 Max G Starceff
REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 23 1927

17. I HEREBY CERTIFY That I attended deceased from
19..... to 19.....
that I last saw h..... alive on....., 19....., and that
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-25927