

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 4737Registration District No. 791Primary Registration District No. 1003Registrar's No. 1567

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town ST. LOUIS MO  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
ST. ANTHONY HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether  
 In this community 2 DAYS  
 years, months or days)

3. (a) PRINT FULL NAME MARY AGNES BOLLER

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If alive \_\_\_\_\_ years

7. Birth date of deceased MARCH 28 1939  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
10 17 hr. min.9. Birthplace ST. LOUIS MO  
(City, town, or county) (State or foreign country)10. Usual occupation NIL11. Industry or business NIL12. Name GUSTAV F BOLLER13. Birthplace ST. LOUIS MO  
(City, town, or county) (State or foreign country)14. Maiden name AGNES MENNE15. Birthplace ST. LOUIS MO  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Gustav Boller(b) Address 2840 Minnesota Ave17. (a) BURIAL (b) Date thereof FEB 17-40  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation NEWSS PETER & PAUL18. (a) Signature of funeral director Thornton(b) Address 2906 Morris19. (a) FEB 16 1940 (b) J. F. Bucher  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County \_\_\_\_\_  
 (c) City or town ST. LOUIS 16  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2840 MINNESOTA AVE  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 14 day 14  
year 1940 hour 11:40 minutes 10 M.21. I hereby certify that I attended the deceased from February 13, 1940, to February 14, 1940;  
that I last saw her alive on Feb. 14, 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Haemolytic Streptococcus Pneumonia. Duration 2 hoursDue to Terminal only about 2 hours durationDue to Intestinal Infection 2daOther conditions no  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_Of autopsy Numerous small Pneumonic patches in lung 4/5 lateral. This was terminal

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Jules C. Rath (M. D. or other) MD  
Address 5603 Cherokee Date signed 2/15/40

**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.....

*Leo Budde*....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Leo Budde*  
Licensed Embalmer No. *3989*

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 this body is not embalmed, above space should be left blank.**