

No. 2
4-13-40
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

33516

State File No. _____

NOV 16 1940 791

1003
Primary Registration District No. _____

Registrar's No. 8213

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Christian Hospital
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 4-Days
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Frank C. Boggs

3. (b) If veteran, name war None

3. (c) Social Security No. 488-09-2416

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced S.

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 25, 1904
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

35 10 6 hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Auditor 0

11. Industry or business Auto Sales 0

12. Name Frank Boggs

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Ada Julian Mo.
(City, town, or county) (State or foreign country)

15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant William Boggs

(b) Address 6403 Hobart Ave.

17. (a) Burial (b) Date thereof 10-3-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. OCT 2 1940 (b) J. F. [Signature]
(Date received local registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis 10
(If outside city or town limits, write "RURAL")

(d) Street No. 4035 St. Louis Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 1st.
year 1940 hour 4 minute 20 a. m. - p. m.

21. I hereby certify that I attended the deceased from Sept 28
18 1940 to Oct 1 1940
that I last saw him alive on Sept 30 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Aspiration pneumonia 3 days

Due to Tetany 3 days

Due to Chronic gastritis with dilatation

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Aspiration pneumonia; Tetany; Chronic gastritis with dilatation

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 John G. M. [Signature] (M. D. or other) M.D.

Address 1014 Thebes Av Date signed 10/1/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

R

22
4701a St. Louis Ave.
to 3 pm.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed W. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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, fact should be so stated above.