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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32484

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 1836

FILED OCT 7 1941

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 hrs. 20 min. (Specify whether years, months or days) In this community life 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Normandy (If outside city or town limits, write "RURAL")
(d) Street No. 8829 Radian Ave. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME Boschert, Baby Girl
3. (b) If veteran, name war none
3. (c) Social Security No. none
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 Sept. (Month) 3 (Day) 1941 (Year)
8. AGE: Years 0 Months 0 Days 0 If less than one day 15 hr. 20 min.
9. Birthplace Clayton (City, town, or county) Mo. (State or foreign country)
10. Usual occupation none
11. Industry or business
12. FATHER Name Patrick Boschert
13. FATHER Birthplace Unknown (City, town, or county) Mo. (State or foreign country)
14. MOTHER Maiden name Celia Shoemake
15. MOTHER Birthplace Unknown (City, town, or county) Mo (State or foreign country)
16. (a) Informant Patrick Boschert
(b) Address 8829 Radian
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-41 (Month) (Day) (Year)
(c) Place: burial or cremation Lenox, Mo.
18. (a) Signature of funeral director Patrick Boschert Father
(b) Address 8829 Radian
19. (a) SEP - 4 1941 (Date received local registrar) (b) C. G. McGaron (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3 year 1941 hour 9 minute :00 P. M.
21. I hereby certify that I attended the deceased from 9-3-41, 19..., to 9-3-41, 19...; that I last saw her alive on 9-3-41, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hemorrhage	15 hr.
Due to	
Due to Birth Injury	
Other conditions (Include pregnancy within 3 months of death) None	
Major findings: Of operations	
Of autopsy Small blood clot in tentorium	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Leestall (M. D. or other) M.D.
Address Co. Hosp. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

101

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.....

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 this body is not embalmed, fact should be so stated above.

No. 2B
1-21-41
29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32484

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 1836

1. PLACE OF DEATH

(a) County: St Louis

(b) City or town: Clayton (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Louis Co Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 15 hr. 20 min. (Specify whether years, months or days)

In this community: Life 15 hr. 20 min.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: St Louis

(c) City or town: Normandy (If outside city or town limits, write "RURAL")

(d) Street No.: 8829 Radian ave (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Boschert, Baby Girl

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: F

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: Sept (Month) 3 (Day) 1941 (Year)

8. AGE: Years | Months | Days | If less than one day: hr. 20 min.

9. Birthplace: (City, town, or county) (State or foreign country)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name:
13. Birthplace: (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name:
15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant:
(b) Address:

17. (a) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)
(c) Place: burial or cremation:

18. (a) Signature of funeral director:
(b) Address:

19. (a) 9-4-41 (Date received local registrar) (b) R S McSamara MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept Day: 3 Year: 1941 hour: minute: M.

21. I hereby certify that I attended the deceased from: 19 to 19;
that I last saw him alive on: 19;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

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

23. Signature: (M. D. or other)
Address: Date signed:

SUPPLEMENTARY