S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 4 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36625

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4710

1. PLACE OF DEATH:

(a) County Jackson

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

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

(d) Length of stay: In hospital or institution Few hours 0 (Specify whether
In this community None same
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ~~Jackson~~ Carroll 17

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

(d) Street No. Missouri
(If rural, give location)

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

If yes, name country 1

3. (a) PRINT FULL NAME Anna Boschert

3. (b) If veteran, name war No

3. (c) Social Security No. 489-22-7664

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Boschert

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased July (Month) 15th (Day) 1890 (Year)

8. AGE: Years 54 Months 4 Days 8 If less than one day hr. min.

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

10. Usual occupation Lake City Ord.

11. Industry or business & Housewife

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

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

16. (a) Informant William Boschert
(b) Address Norborne Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/44 (Month) (Day) (Year)
(c) Place: burial or cremation Norborne Mo.

18. (a) Signature of funeral director Earp Funeral Home
(b) Address Kansas City, Mo.

19. (a) 11-23-44 (Date received local registrar) (b) T. E. Brown (Sig) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 23rd. year 1944 hour 9 minute 84 A.M.

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

Immediate cause of death shock due to multiple fractures Railroad trauma

Due to (car and train)

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy see above

Duration 8

1700 23

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) accident 048

(b) Date of occurrence 11-23-44

(c) Where did injury occur? Jackson Co., Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? public place (Specify type of place)

While at work? no (e) Means of injury trauma

23. Signature A. E. Ussher (M.D. or other) M.D.

Address 23 McCoy Date signed 11-23-44

(Licensed Embalmer's Statement on Reverse Side)

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 John B. Earp

Licensed Embalmer No. 2955

P. O. Address K. C. 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, fact should be so stated above.