

FILED MAR 9 1945

Registration District No. 1000 Primary Registration District No. 1000

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2117 Faraon St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 12 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2117 Faraon St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Clara A. Boldenweck  
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 Widowed  
6. (b) Name of husband or wife Fred. W. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 12 1872  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month February day 16  
year 1945 hour 7 minute 45 P. M.  
21. I hereby certify that I attended the deceased from Jan 6 1943 to Feb. 16 1945  
that I last saw him alive on Feb. 16 1945  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>8</u>	<u>4</u>	hr. _____ min.

Immediate cause of death Endo Carditis Chy-  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Thromb. emb. illae  
(Include pregnancy within 3 months of death)  
Salary - 2/15/45  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Chicago Illinois  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife  
11. Industry or business None  
12. Name Emil Ernst  
13. Birthplace Chicago Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Lina Colbar  
15. Birthplace Chicago Illinois  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Phil P. Sheridan  
(b) Address 2117 Faraon St.  
17. (a) Removal (b) Date thereof Feb. 17, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Chicago Illinois  
18. (a) Signature of funeral director Arnold W. Gendyadew  
(b) Address 1802 Union St. St. Joseph, Mo.  
19. (a) 2-17-45 (b) Robert J. Feller  
(Date received local registrar) (Registrar's signature)

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 0  
23. Signature Frank Neideman (M. D. or other)  
Address 620 Juncit Date signed 2/17/45

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

MAY 16 1945

**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 Keith Collins

Licensed Embalmer No. 3632

P. O. Address St Joseph 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.**