

No. 2
M-543
7. 5-17-39
I X38671

FILED JAN 13 1947
42

Registration District No. **42** 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:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Da. (Hospit'l.)**
(Specify whether years, months or days) **50 Years**

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. **1927 Union St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country *****

3. (a) PRINT FULL NAME **Ottillie A. Boegle**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **December**, day **31**, year **1946**, hour **11**, minute **20 P.M.**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Henry** 6. (c) Age of husband or wife if alive **46** years
7. Birth date of deceased **July 13 1859**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **August 19, 1946** to **31 Dec. 1946**
that I last saw her alive on **31 Dec. 1946**
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	87	5	18	hr. min.

Immediate cause of death **Hypostatic Bronchopneumonia** *1 day*
Due to **Generalized Arteriosclerosis** *several years*
Senility *several years*
Due to **Malnutrition** *1-2 mo.*
Other conditions **Secondary anemia** *1-2 mo.*
(Include pregnancy within 3 months of death)

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

Major findings: Of operations **none**
Of autopsy **none**
PHYSICIAN
Underline the cause to which death should be charged statistically.

10. Usual occupation **Housewife**

11. Industry or business **None**

MOTHER { 12. Name **Nicholas Jost**
13. Birthplace **Unknown Germany**
14. Maiden name **Susanna Roeder**
15. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Gladys Boegle**
(b) Address **1927 Union St.**

17. (a) **Burial** (b) Date thereof **Jan. 3, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Olivet Cemetery**

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? _____

18. (a) Signature of funeral director **Therman W. Deufel**
(b) Address **1802 Union St. St. Joseph, Mo.**
19. (a) **1-6-47** (b) **G. B. Jenkins**
(Data received local registrar) (Registrar's signature)

While at work? **Q** (Specify type of place)
(c) Means of injury _____
23. Signature **Thompson P. Botta** (M. D. or other) **M.D.**
Address **415 Conly Bldg.** Date signed **7 Jan 47**

282 (Licensed Embalmer's Statement on Reverse Side) **St. Joseph, Mo.**

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

100-50

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 Emr Thomas

Licensed Embalmer No. 2640

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.