

No. 2
M-5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11894**
Registrar's No. **597**

FILED MAR 21 1947

Registration District No. **3174**

Primary Registration District No. **6076**

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

1. PLACE OF DEATH:

(a) County **ST. LOUIS**

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

(c) Name of hospital or institution: **3723 MANOLA**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **5 YEARS** (Specify whether years, months or days)

In this community **5 YEARS**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS**

(c) City or town **PINE LAWN**
(If outside city or town limits, write "RURAL")

(d) Street No. **3723 MANOLA**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MAMIE BOSWELL**

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 **WIDOW**

6. (b) Name of husband or wife **MILTON T. BOSWELL**

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

7. Birth date of deceased **AUG-12-1864**
(Month) (Day) (Year)

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

82 **4** **27** hr. min.

9. Birthplace **LITTLE ROCK - ARK.**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business _____

MOTHER FATHER { 12. Name **SAMUEL BELOATED**

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

14. Maiden name **ELIZABETH NOEL**

15. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Eunice Mann**

(b) Address **3723 Manola ave.**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **3-18-47**
(Month) (Day) (Year)

(c) Place: burial or cremation **BELLEFONTAINE CEM**

18. (a) Signature of funeral director **J. N. Shaw**

(b) Address **6107 Natural Bridge**

19. (a) **3-17-47** (Date received local registrar)

(b) **[Signature]** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **mch** day **15** year **1947** hour **2** minute **P** M.

21. I hereby certify that I attended the deceased from **Dec 14**, 1946, to **mch 15**, 1947; that I last saw her alive on **mch 14**, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death **Organic Valvular Heart Lesion** Duration **6 mo.**

Due to _____ **95**

Due to _____

Other conditions **nephritis**
(Include pregnancy within 3 months of death)

Major findings: Of operations **no**

Of autopsy **no**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury **0**

23. Signature **J. N. Shaw** (M. D. or other)

Address **2330 Union** Date signed **mch 16/47**

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

Jay W. Wilkerson

Licensed Embalmer No. *3575*

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.