

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 25 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 999

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:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days (Specify whether
In this community 4 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt
(c) City or town New Point
(If outside city or town limits, write "RURAL")
(d) Street No. 11 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Lodemia Alice Boswell

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Robert W. Boswell 6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased December 20 1875
(Month) (Day) (Year)

8. AGE: Years 71 Months 77 Days 27 If less than one day
hr. min.

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

10. Usual occupation At Home

11. Industry or business

12. Name Thomas Romine
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Susan Leffler
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Robert W. Boswell
(b) Address New Point, Missouri
17. (a) Burial (b) Date thereof August 19 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation New Point, Missouri
18. (a) Signature of funeral director [Signature]
(b) Address [Address]
19. (a) Aug 21, 1947 (b) [Signature]
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month August day 17
year 1947 hour 4 minute 30 P. M.
21. I hereby certify that I attended the deceased from Aug 14, 1947, to Aug 18, 1947,
that I last saw him alive on Aug 17, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion 4 days
Due to Coronary Arteriosclerosis

Other conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

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 0
23. Signature T. R. Houlder (M. D. or other) M.D.
Address 620 Main St Date signed 8-20-47

Duration
Physician
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 *A. H. Crawford*

Licensed Embalmer No. 1824

P. O. Address Mound Bay, 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.