

RECEIVED SEP 29 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32655**  
Registrar's No. **18**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **306** PRIMARY REG. DIST. NO. **6048**

920

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

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Peters</b> <b>DARDENNE TWP</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Peters</b> <b>DARDENNE TWP.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <b>0925</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Emil</b> b. (Middle) <b>Albert</b> c. (Last) <b>Boersig</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>9-20-52</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>11-21-1878</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>0</b>	IF UNDER 24 HRS. Hour <b>0</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cabinetmaker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	11. BIRTHPLACE (State or foreign country) <b>St. Peters, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Peter A. Boersig</b>	13b. MOTHER'S MAIDEN NAME <b>Magdalena Obres</b>	14. NAME OF HUSBAND OR WIFE <b>Agnes Obrecht</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Lillian M. Mahon, St. Peters, Mo.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma right Lung</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 19 52** to **Sept 20, 19 52**, that I last saw the deceased alive on **Sept 15, 19 52**, and that death occurred at **4:05 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Vernice Schneider</b> (Degree or title)	23b. ADDRESS <b>St. Charles, Mo.</b>	23c. DATE SIGNED <b>Sept 21-52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>9-23-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>All Saints</b>	24d. LOCATION (City, town, or county) (State) <b>St. Peters, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Sept 22 52</b>	REGISTRAR'S SIGNATURE <b>E.A. Reithly</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>St. Peters, Mo.</b>
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JUL 13 0 1954

APR 21 1954

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed E. Keenly

Licensed Embalmer No. 822

P. O. Address Orallon m

**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.