

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4684

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. CITY	
b. CITY OR TOWN <u>ST. LOUIS MO</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL</u>		16. STREET ADDRESS (If rural, give location) <u>3150 ARSENAL</u> <u>2169</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u> b. (Middle) <u>MARIE</u> c. (Last) <u>BOEMLER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 24 1954</u>		
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, <u>WIDOWED</u> , DIVORCED (Specify)	
8. DATE OF BIRTH <u>FEB. 11 1873</u>		9. AGE (in years last birthday) <u>81</u>		10. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>AT HOME</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <u>GERHARDT NIEMANN</u>		13b. MOTHER'S MAIDEN NAME <u>LOUISA</u>		14. NAME OF HUSBAND OR WIFE <u>Geo. A. BOEMLER (DEC'D)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>IRENE DEACHAN 3150 ARSENAL</u>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma Left Breast</u> DUE TO (b) <u>Generalized Metastases</u> DUE TO (c) <u>Hypertension</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>170X</u>	
22. I hereby certify that I attended the deceased from <u>May 4, 1954</u> to <u>May 24, 1954</u> , that I last saw the deceased alive on <u>5/24</u> , 19 <u>54</u> , and that death occurred at <u>7:30 P</u> m., from the causes and on the date stated above.					

23a. SIGNATURE <u>W. W. Wagnenbach M.D.</u> (Degree or title)		23b. ADDRESS <u>4717 Morganford</u>		23c. DATE SIGNED <u>5/25/54</u>	
24a. BURIAL, CREMATION REMOVAL (Specify) <u>REMOVAL</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ST. MARTIN CEM</u>		24d. LOCATION (City, town, or county) (State) <u>HIGH RIDGES MO</u>	

DATE REC'D BY-LOCAL REG. <u>MAY 26 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutis 2906 Shaveria</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed *Samuel C. Hill*.....

Licensed Embalmer No. *434*.....

P. O. Address *2906*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.