

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37600

STATE FILE NUMBER

FILED NOV 19 1956

Registration District No. 118 Primary Registration District No. 5440 Registrar's No. 42

Health, Welfare Public Service  
300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clay Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Blanc</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>AT home</u> Length of stay in lb <u>8 yrs</u>		d. STREET ADDRESS (If possible, give location) <u>RFD. - BLANC</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BARBARA Rose Boesch</u> First Middle Last		4. DATE OF DEATH <u>Nov 7 - 1956</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19 - 1884</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Registered Nurse</u>	9c. AGE (In years last birthday) <u>72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Registered Nurse</u>	10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
11. BIRTHPLACE (City and state or country) <u>Swiss - Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Boesch</u>		14. MOTHER'S MAIDEN NAME <u>Doris Drewell</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. <u>496-36-4668</u>	
17. INFORMANT <u>Maurice Boesch - Belle - Mo</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Myocardial Regeneration</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY _____ a. m. _____ p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	
21. I attended the deceased from <u>10/2/56</u> to <u>11/7/56</u> and last saw her/him alive on <u>11/6/56</u> Death occurred at <u>6:15</u> a. m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deduce or title) <u>R. H. Schouharts, M.D.</u>		22b. ADDRESS <u>Belle, Mo</u>	
22c. DATE SIGNED <u>11/9/56</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>Nov 9 - 1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Zions E.P. Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Blanc - Mo.</u>		23e. STATE <u>Mo.</u>	
24. PREPARE DIRECTOR <u>State Sanitary General Service</u>		25. DATE RECD. BY LOCAL REG. <u>November 13, 1956</u>	
26. REGISTRAR'S SIGNATURE <u>Christ Saeman</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Marie Jappney</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *Chester Sassano*.....

Licensed Embalmer No. *417*

P. O. Address *Bland*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If  
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.