

Health,
Welfare
Public
Service

FILED AUG 1 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026756
STATE FILE NUMBER
7356

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

9
306
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2042 Victor St.		d. STREET ADDRESS (If outside, give location) 2042 Victor St.	
3. NAME OF DECEASED (Type or print) Lena C. Boll		4. DATE OF DEATH Month July Day 26 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10th, 1863
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 95
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Fred C. Springmeyer		13b. MOTHER'S MAIDEN NAME Wilhelmina Hoerner	
13c. SOCIAL SECURITY NO.		14. NAME OF HUSBAND OR WIFE Charles P. Boll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Charlotte E Boll Address 2042 Victor St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS
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 Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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 April 1958 to 7/26/58 and last saw her alive on 7/26/58 Death occurred at 2:00 P.M. - 7/26/58 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) Paul P. Webb, M.D.		22b. ADDRESS 1915^a Sidney	
22c. DATE SIGNED 7/29/56			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7/29/58	
23c. NAME OF CEMETERY OR CREMATORY St. Peters		23d. LOCATION (City, town, or county) (State) Normandy, Mo.	
24. FUNERAL DIRECTOR Harry A. Kraeger ADDRESS 222 Crandon Dr., Clayton 24, Mo.		25. DATE RECD. BY LOCAL REG. JUL 28 '58	
26. REGISTRAR'S SIGNATURE Carl Smith MD			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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

Laurence O. Harley

Licensed Embalmer No. *4979*

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