

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002564  
STATE FILE NUMBER

FILED JAN 19 1959 Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 9

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Charles</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>O'Fallon</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		Length of stay in lb <u>25 days</u>	d. STREET ADDRESS (If outside, give location) <u>130 Country Life Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Tilden Everett Bozarth</u>			4. DATE OF DEATH Month Day Year <u>Jan. 11, 1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-1912</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Relations</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u>	9. AGE (In years) <u>46 yr.</u> IF UNDER 1 YEAR: Months <u>3</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Relations</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u>	11. BIRTHPLACE (City and state or country) <u>Staunton, Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Tilden Bozarth</u>	
13b. MOTHER'S MAIDEN NAME <u>Lillian Cool</u>		14. NAME OF HUSBAND OR WIFE <u>Evelyn Talbot Bozarth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>492-09-8667</u>	
17. INFORMANT <u>Evelyn Bozarth</u>		Address <u>O'Fallon, Mo.</u> <u>130 Country Life Dr.</u>	
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>Terminal Cardiac Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</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) <u>Pulmonary Embolism</u>			INTERVAL BETWEEN ONSET AND DEATH <u>None</u>
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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 <u>O'Fallon, Mo.</u>		COUNTY STATE	
21. I attended the deceased from <u>17 Dec 58</u> to <u>10 Jan 59</u> and last saw her alive on <u>10 Jan 59</u> . Death occurred at <u>12:30</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Gene L. Sudman</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>O'Fallon, Mo.</u>	
22c. DATE SIGNED <u>1/12/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1-13-59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Edwardsville, Illinois</u>	
24. FUNERAL DIRECTOR <u>Leonard R. Davis</u>		ADDRESS <u>2060 Cleveland</u>	
25. DATE RECD. BY LOCAL REG. <u>JAN 12 59</u>		26. REGISTRAR'S SIGNATURE <u>Marcella L. Wilson</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 20 1959

FEB 24 1959

JAN 26 1959

FEB 1 1959

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 *Leonard R. Darrow*

Licensed Embalmer No. *4959*

P. O. Address *Granite City*

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.