

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED JUN 22 1959

59-020431

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 635

STATE FILE NUMBER

WENDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Buchanan</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in lb <b>50 yrs.</b>		c. CITY OR TOWN <b>St. Joseph</b>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Parkview Nursing Home 1212 Dewey Ave.,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>1114 North 25th St.,</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALTER BOSCHEN</b>				4. DATE OF DEATH Month Day Year <b>June 16, 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/30/1881</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Architect</b>		11. BIRTHPLACE (City and state or country) <b>New Haven, Conn.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Diedrich Boschchen</b>		13b. MOTHER'S MAIDEN NAME <b>Hulda VonBeust</b>		14. NAME OF HUSBAND OR WIFE <b>Oma Cynthia Boschchen</b>			
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. <b>497-40-6408</b>		17. INFORMANT Address <b>Ethel Farthing, St. Joseph, Missouri</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b> <b>acute Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Pulmonary Fibrosis</b> DUE TO (c) <b>Arteriosclerosis general</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 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 COUNTY STATE	
21. I attended the deceased from <b>4-23-52</b> to <b>6-16-59</b> and last saw him alive on <b>6-15-59</b> Death occurred at <b>3:45</b> <b>A</b> am on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Wm. B. Rost</b>				22b. ADDRESS <b>316 No 10th St Joseph Mo</b>		22c. DATE SIGNED <b>6-16-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>June 18, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>St. Joseph, Missouri</b>				25. DATE RECD. BY LOCAL REG. <b>June 18, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Licensed Embalmer No. 4679

P. O. Address St. Joseph,

Missouri

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.