

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

**FILED VS FEB 25 1960**

**-60-007967**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 1041** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b <b>3 Days</b>		c. CITY OR TOWN <b>Richmond Heights</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1217 Bellevue Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN CALVERT BOSTON</b>				4. DATE OF DEATH Month Day Year <b>Jan. 27, 1960</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 12, 1905</b>	9. AGE (last birthday) <b>54</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b>	IF UNDER 24 HR Hours <b>15</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>H.H. Hall Const. Co.</b>		11. BIRTHPLACE (City and state or country) <b>Versailles, Ky.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>John Boston</b>			13b. MOTHER'S MAIDEN NAME <b>Grace Hudson</b>			14. NAME OF HUSBAND OR WIFE <b>Katherine Boston</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War II</b>			16. SOCIAL SECURITY NO. <b>702-16-5984</b>		17. INFORMANT Address <b>Katherine Boston 1217 Bellevue Ave.</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>Lymphosarcoma</b>							INTERVAL BETWEEN ONSET AND DEATH <b>9 mos</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>200.1</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 checked="" type="checkbox"/> NO <input 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 Month, Day, Year 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 <b>11/6/59</b> to <b>1/27/60</b> and last saw <sup>her</sup> him alive on <b>1/27/60</b> Death occurred at <b>4 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>John B. Shapleigh M.D.</b>				22b. ADDRESS <b>3720 Washington St. Louis Mo</b>			22c. DATE SIGNED <b>1/28/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Feb. 1, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Lawn Cemetery</b>			23d. LOCATION (City, town, or county) <b>Little Rock Ark.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>A.H. Bocklage F.H. 6536 Clayton Rd.</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 29 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>			

INDEXED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Elmo R. Sadler

Licensed Embalmer No. 4077

P. O. Address St Louis

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.