

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028126

FILED VS. JUL 22 1960

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Registration District No. 1003

Registrar's No. 6835

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 5 da		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1115 Howell		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First MARIE Middle LORETTE Last BOEDFELD				4. DATE OF DEATH Month July Day 5th Year 1960									
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 8/4/92		9. AGE (last birthday) 67		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Joseph Collet				13b. MOTHER'S MAIDEN NAME Mary Kihn				14. NAME OF HUSBAND OR WIFE Bernard J. Boedefeld					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 499-28-6744		17. INFORMANT Address Marie Knouse, 1115 Howell							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 420.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 4 days several yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Pulmonary congestion								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 5-10-60 to 7-6-60 and last saw her ^{her} _{him} alive on 7-5-60 Death occurred 12:15 AM on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) a. Steiner M.D.						22b. ADDRESS 3720 Washington			22c. DATE SIGNED 7/6/60				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 7/9/60		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			23d. LOCATION (City, town, or county) (State) St. Louis, Mo.						
24. FUNERAL DIRECTOR ADDRESS DIEDRICH FUNERAL HOME, 8319 Hallsferry				25. DATE RECD. BY LOCAL REG. JUL 7 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.							

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 *Robert M. Murray*

Licensed Embalmer No. 374

P. O. Address St Louis

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

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