

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 6 1960

318

1003

8424

-60-031918

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8424

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>3 days</u>		c. CITY OR TOWN <u>Webster Groves</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>318 Marion</u>	
				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Benjamin M.</u> Middle <u>Boulware</u> Last			4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1960</u>		
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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>12/14/76</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Order Clerk</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Boyd Welsh Shoe Co</u>	11. BIRTHPLACE (City and state or country) <u>Hopkinsville Ky</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Richard Boulware</u>	13b. MOTHER'S MAIDEN NAME <u>Flora Ritter</u>	14. NAME OF HUSBAND OR WIFE <u>Mollie T. Boulware</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>	16. SOCIAL SECURITY NO. <u>489-03-7971</u>	17. INFORMANT <u>Mrs Mollie T. Boulware</u> Address <u>318 Marion Ave</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Pulmonary Edema with Bronchopneumonia</u>		<u>2-3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arterio. nephrosclerosis</u>	<u>1-2 year</u>
	DUE TO (c) <u>Carcinoma of Prostate</u>	<u>1-2 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>177X</u>		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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
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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>St. Louis</u> COUNTY <u>St. Louis</u> STATE <u>Mo</u>
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21. I attended the deceased from <u>Jan 5 1959</u> to <u>Aug 23 1960</u> and last saw him alive on <u>Aug 23 1960</u> Death occurred at <u>11:00 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. K. Roberts</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>110 S. Houbert Clayton</u>	22c. DATE SIGNED <u>8/26/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug 27, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis County Mo</u> (State)
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24. FUNERAL DIRECTOR <u>Shepard Funeral Home, 1167 Hamilton Ave</u>	25. DATE REC'D. BY LOCAL REG. <u>AUG 28 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

