

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017395

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4540**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 2 1963

VS:300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits
		St. Louis		6 days	Mo		St. Louis		Richmond Heights		Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits	d. STREET ADDRESS (If outside, give location)				Reside on Farm		
St. Anthony's Hospital				Yes <input type="checkbox"/> No <input type="checkbox"/>	7342 Ethel Avenue				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year	
			LOUIS	WILLIAM	BOERNEMANN	April 24, 1963					
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY		
Male	White		4/6/1893	70	Ret. 1960 Maintenance Dept		St. Louis, Missouri		U.S.A.		
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE					
Wilhelm Boernemann			Anna Grote			Ruth O. Upchurch Boernemann					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						17. INFORMANT		Address			
Yes <input checked="" type="checkbox"/> WW I						Mrs. Ruth Boernemann		7342 Ethel Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:											6 mos
IMMEDIATE CAUSE (a) <i>Bronchogenic Ca</i>											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
DUE TO (b) <i>1621</i>											
DUE TO (c)											
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 <i>October 1962</i> to <i>April 24, 1963</i> and last saw him ^{her} alive on <i>April 24, 1963</i>											
Death occurred at <i>5:30 P</i> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE					(Degree or title)	22b. ADDRESS			22c. DATE SIGNED		
<i>William Gillespie MD</i>						3720 Washington Blvd, St. Louis			4/25/63		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)	
Removal			April 29, 1963	National Cemetery			Jefferson Barracks, Missouri				
24. FUNERAL DIRECTOR					ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE		
Ambruster Mortuary					6633 Clayton Road		APR 25 1963		<i>Lead Smith. M.D.</i>		

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

Paul J. Starnes

Licensed Embalmer No. 4788

P. O. Address St. Louis, Mo

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.