

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017407

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4066**

FILED APR 17 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		Length of stay in 1b 5 weeks		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE Missouri b. COUNTY		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 ST. LOUIS CITY HDSP #1.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1406 Benton Street				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THEODORE Middle J. Last BOSSERT						4. DATE OF DEATH APR 10, 1963					
5. SEX male		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 5-14-1879		9. AGE (last birthday) 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance Man				10b. KIND OF BUSINESS OR INDUSTRY American Bed & Spring Co.		11. BIRTHPLACE (City and state or country) O'Fallon, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Charles Bossert				13b. MOTHER'S MAIDEN NAME Kate Schuette				14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of no				16. SOCIAL SECURITY NO. 20		17. INFORMANT Address Mr. John T. Bossert, 3321 N. 19th Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE										INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b): ASHD											
DUE TO (c): 420.0H											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CA prostate, suspected metast. melanoma										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 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 2/17/63 to 4/9/63 and last saw her/him alive on 4/9/63 Death occurred at 5:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) J. E. Smith M.D.						22b. ADDRESS 1515 LAFAYETTE AVE.			22c. DATE SIGNED 4/9/63		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4-12-63		23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery		23d. LOCATION (City, town, or county) St. Louis, Missouri.				(State)	
24. FUNERAL DIRECTOR ADDRESS Math Hermann and Son, Inc. 2161 E. Fair Ave. St. Louis, Missouri.						25. DATE RECD. BY LOCAL REG. APR 11 1963		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

BRITISH INK
OR
TYPEWRITER RIBBON

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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 me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed *Arthur W. Kay*

Licensed Embalmer No. 3737

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.