

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-042240

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3146

STATE FILE NUMBER

FILED OCT 30 1963

VS 300 Rev. 4/59	DATE AMENDED
14003	
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1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		Length of stay in 1b 4 days	c. CITY OR TOWN Fenton 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. Joseph Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 980 Gravois Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARIE Middle BOEHMER Last BOEHMER		4. DATE OF DEATH Month Oct. Day 12, Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-6-1873
9. AGE (last birthday) 90		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Wurtemberg, Germany
12. CITIZEN OF WHAT COUNTRY US A		13. FATHER'S NAME Johnaess Schill	
13b. MOTHER'S MAIDEN NAME Barbara Goetz		14. NAME OF HUSBAND OR WIFE E. Julius Boehmer	
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. None	
17. INFORMANT Fenton, Mo. Address E. Julius Boehmer-980 Gravois Rd.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO (b) Mediastinal tumor, type unknown DUE TO (c) ? Aortic aneurysm, type unknown INTERVAL BETWEEN ONSET AND DEATH Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Medical Compression		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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 10/6/63 to 10/12/63 and last saw her/him alive on 10/12/63 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>James Overmire MD</i> (Degree or title)		22b. ADDRESS 634 N. Grand	
22c. DATE SIGNED 10/15/63		22d. DATE SIGNED (State)	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	23b. DATE 10-15-1963	23c. NAME OF CEMETERY OR CREMATORY New Pickers Cem.	23d. LOCATION (City, town, or county) St. Louis, Mo.
24. FUNERAL DIRECTOR Pfitzinger Mort-Kirkwood 22, Mo. ADDRESS		25. DATE RECD. BY LOCAL REG. 10-14-63	
26. REGISTRAR'S SIGNATURE <i>John C. ...</i>		26. REGISTRAR'S SIGNATURE	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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,

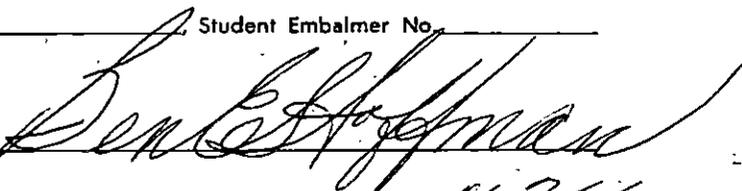
or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____

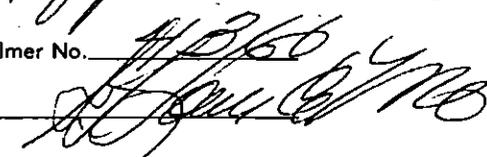
Signature of Student Embalmer

Signed



Licensed Embalmer No. _____

P. O. Address _____



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.

SPR-1-02