

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12059

63-045247
STATE FILE NUMBER

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

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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		Length of stay in 1b 11 days		c. CITY OR TOWN ST. LOUIS (Wellston)		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (IF NOT HOSPITAL OR INSTITUTION) Coburne Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6312 WELLS AVE.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First SILAS Middle W Last BOSWELL			4. DATE OF DEATH Month DECEMBER Day 5 Year 1963			5. SEX MALE		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 8-17-12		9. AGE (last birthday) 51		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Special Agent				10b. KIND OF BUSINESS OR INDUSTRY Terminal Railroad		11. BIRTHPLACE (City and state or country) Vicksburg, mississippi		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Clyde Boswell			13b. MOTHER'S MAIDEN NAME Maude G. Cannon			14. NAME OF HUSBAND OR WIFE Myrtle Boswell			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII	
16. SOCIAL SECURITY NO.			17. INFORMANT Address Myrtle Boswell (Wife) See #2			18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE DUE TO (b) _____ 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 Month, Day, Year s.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 VAH, ST. LOUIS, MISSOURI		COUNTY STATE		
21. <input checked="" type="checkbox"/> attended the deceased from 11-25-63 , to 12-5-63 and last saw him alive on 12-5-63		Death occurred at 7:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE T. [Signature] (Degree or title) M.D.			22b. ADDRESS VAH, ST. LOUIS, MISSOURI			22c. DATE SIGNED 12-5-63				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Dec 7, 1963		23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Missouri				
24. FUNERAL DIRECTOR Shepard Funeral Chapel ADDRESS Natural Bridge Rd			25. DATE RECD. BY LOCAL REG. DEC 6 1963		26. REGISTRAR'S SIGNATURE Loat Smith, M.D.					

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,

_____ Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Lawrence O. Heeling

Licensed Embalmer No. 4979

P. O. Address Berkely, 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.