

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**68-050154**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 367 Primary Registration District No. 500 Registrar's No. 3937 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

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Ferdinand Twp</b>		Length of stay in 1b <b>38 yrs</b>		c. CITY OR TOWN <b>St. Ferdinand Twp</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1090 Belgrove</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1090 Belgrove</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>F.</b> Last <b>BOEDFELD</b>			4. DATE OF DEATH Month <b>December</b> Day <b>21st</b> , Year <b>1963</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/85</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Frank Boedefeld</b>			13b. MOTHER'S MAIDEN NAME <b>Gertrude Schuette</b>		14. NAME OF HUSBAND OR WIFE <b>Anna Boedefeld</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Anna Boedefeld, 1090 Belgrove</b>		
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) <b>Hypertension, C.V. disease</b>						<b>7 yrs.</b>	
DUE TO (b) <b>Coronary Arteriosclerosis</b>						<b>6 mos.</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) <b>Serology</b>						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 <u>7-15-63</u> to <u>12-21-63</u> and last saw <sup>him</sup> <del>her</del> alive on <u>12-17-63</u> Death occurred at <u>7:35</u> <sup>P</sup> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>J. Weygand</i> (Degree or title) <b>MD</b>			22b. ADDRESS <b>832 1/2 Broadway (47)</b>			22c. DATE SIGNED <b>12-23-63</b> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>12/24/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>EMIL J. HEITZENROEDER, 8319 Hallsferry</b>			25. DATE RECD. BY LOCAL REG. <b>12-23-63</b>		26. REGISTRAR'S SIGNATURE <i>John G. Murphy MD</i>		

USE BLACK INK OR TYPEWRITER RIBBON

12-11-1914

12-11-1914

12-11-1914

12-11-1914

of the body of the deceased  
was embalmed by me

of the body of the deceased  
was embalmed by me

Signature of Student Embalmer  
Date of Embalming  
City and State

Signature of Licensed Embalmer  
Date of Embalming  
City and State

**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 Harvey K. Hile

Licensed Embalmer No. 4596

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.