

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County

Gascade

Township

Boeuf

or

Village

or

City

(NO.)

Registration District No.

306

File No.

16785

Primary Registration District No.

5424

Registered No.

4

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

Barbar Boesch

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Married

DATE OF BIRTH

Dec

25

1894

(Month)

(Day)

(Year)

AGE

57

yrs.

4

mos.

25

ds.

If LESS than
1 day, ____ hrs.
or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

General Housework

BIRTHPLACE

(City or town, State or foreign country)

Swiss P. O. Mo.

PARENTS

NAME OF FATHER

Andrew Boesch

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Switzerland

MAIDEN NAME OF MOTHER

Christine Fleck

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Switzerland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Adolph Boesch

(ADDRESS)

Swiss P. O.

Filed

May 20

1912

D. Frederick L. Mo.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

May

20

1912

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from
Jan 4, 1912, to May 20, 1912
that I last saw her alive on May 20, 1912,
and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Acute Apoplexy

874
118C

(Duration)

yrs.

mos.

ds.

Contributory
(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

F. W. Boeschmann M. D.

May 20 1912

(Address) Bay P. O. Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Home Cemetery

DATE OF BURIAL

May 23 1912

UNDERTAKER

Herman Blumen

ADDRESS

Bay P. O. Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

County _____

Township _____ or Village _____ or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(NO. _____) St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH _____ (Month) _____, 191____ (Day) _____, 191____ (Year) _____

AGE _____ yrs. _____ mos. _____ ds. or _____ min.?

IF LESS than 1 day, _____ hrs.

OCCUPATION _____

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE _____

(City or town, State or foreign country)

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER _____

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER _____

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (Day) _____, 191____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 191____ (Address)

*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ **DATE OF BURIAL** _____, 191____

UNDERTAKER _____ **ADDRESS** _____