

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

Do not use this space.

14844

**1. PLACE OF DEATH**

County.....  
Township.....  
City, *St. Louis*

Registration District No. **791**  
Primary Registration District No. **1003**

File No.....  
Registered No. **3738**  
St. .... Ward

**2. FULL NAME**

*Lydia Boeke*

(a) Residence. *4235 No. Newstead* St. *10* Ward.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 26 1869*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*58 10 6*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Housework*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis Mo*  
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Adolph Boeke*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Germany*  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Katharine Wolf*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Germany*  
(STATE OR COUNTRY)

14. INFORMANT *J. M. Boeke*  
(Address) *4235 Newstead*

15. APR - 1 1928 *Mar C Stanley* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 28 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Mich - 14 - 1928*, to *Apr. 2 - 1928* that I last saw him alive on *4 - 2 - 1928*, and that death occurred, on the date stated above, at *5:20 p.m.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Acute Toxic Gastric Myocarditis Chronic*

CONTRIBUTORY (SECONDARY) *Chronic*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Chemical*  
(Signed) *Charles H. Smith, M.D.*

*4/3 - 1928 (Address) 305 Metropolitan Bldg*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *St. John's North* DATE OF BURIAL *April 5 1928*

20. UNDERTAKER *Wm. F. Paschedag*  
ADDRESS *2825 No Grand Bl*

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.

