

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FEB 17 1940

791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

254

Registration District No. \_\_\_\_\_

1000

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

254

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
City Hospital, #1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Day  
 (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME Evelyn Boswell 2808. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife John Boswell 6. (c) Age of husband or wife if alive 44 years  
 7. Birth date of deceased Jan 1 - 1899  
 (Month) (Day) (Year)

8. AGE: Years 40 Months 8 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife11. Industry or business William Stegemyer

12. Name \_\_\_\_\_

18. Birthplace Mo  
(City, town, or county) (State or foreign country)14. Maiden name Johnson15. Birthplace Germany  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature John Boswell(b) Address 2531 Benton17. (a) Cremation (b) Date thereof 1-11-40  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Valhalla18. (a) Signature of funeral director Sullivan(b) Address 2849 N. Leland19. (a) JAN 9 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 20  
City of St. Louis  
 (c) City or town \_\_\_\_\_  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2531 Benton  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9,  
year 1940 hour 4:50 minute A. M.21. I hereby certify that I attended the deceased from January  
8, 1940 to January 9, 1940,that I last saw her alive on January 9, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Metastasis  
from Carcinoma  
of left Breast.  
 Due to Post. Operative months.

Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations 50

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_23. Signature E. J. Peters (M. D. or other)  
Address 151 St. Lafayette Date signed 1/9/40

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Albert Mayfield*  
3677

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 this body is not embalmed, above space should be left blank.**