

Registration District No. **784**

Primary Registration District No. **101**

Registrar's No. **975**

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **Clayton**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Louis County Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **28 days**  
In this community **3 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Anna Boelckow** **H 20**

3. (b) If veteran, name war **?** 3. (c) Social Security No. **710**

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widow**

6. (b) Name of husband or wife **Albert Boelckow** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **March 13 1867**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>73</b>	<b>2</b>	<b>5</b>	hr. min.

9. Birthplace **Lacona N. Y.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **nil.**

11. Industry or business

MOTHER FATHER

12. Name **Unknown Ridgeway** **9**

13. Birthplace **Unknown N.Y.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Eliza Baxter**

15. Birthplace **Unknown Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Anna J. Appleby**

(b) Address **7515 Forsythe**

17. (a) **Burial** (b) Date thereof **May 31 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter's Cemetery**

18. (a) Signature of funeral director **J. J. Quinn**

(b) Address **1389 Alameda**

19. (a) **MAY 20 1940** (b) Registrar's signature **D. R. Meyer**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**  
(c) City or town **Clayton**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **7515 Forsythe**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? **years.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **18**  
year **1940** hour **11** minute **:45 A.M.**

21. I hereby certify that I attended the deceased from **4-20-40**  
to **5-18-40**, 19\_\_\_\_, to **5-18-40**, 19\_\_\_\_;  
that I last saw her alive on **5-18-40**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Gas gangrene - left foot & leg** **3 weeks**  
**Duration**

Due to **Arteriosclerosis - Hypertension** **10 years**

Due to **Leukemia**

Other conditions. (Include pregnancy within 3 months of death) **97**

PHYSICIAN

Major findings: Of operations

Of autopsy

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?

**707**  
While at work? (Specify type of place) (e) Means of injury

23. Signature **Merwin S. Murphy** (M. D. or other) **11. 1**

Address **St. Louis County Hospital** Date signed **5-20-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

6  
2  
2

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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 BW Train

Licensed Embalmer No. 1591

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.**