

Registration District No. 772

Primary Registration District No. 4463

Registrar's No. 970

1. PLACE OF DEATH

(a) County St. Louis  
(b) City or town St. Louis, Mo.  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community

years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME

John Wesley Boswell 240

8. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife Ella Boswell

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 4 73  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

68 7 27

4

27

hr. min.

9. Birthplace

St. James, Mo.  
(City, town, or county)

Mo.  
(State or foreign country)

10. Usual occupation

Business

11. Industry or business

MOTHER FATHER

12. Name Jacob Boswell

13. Birthplace Pa.  
(City, town, or county)

13. Birthplace Pa.  
(City, town, or county)

14. Maiden name Elizabeth Perrier

14. Maiden name Pa.

15. Birthplace \_\_\_\_\_  
(City, town, or county)

15. Birthplace Mo.  
(City, town, or county)

16. (a) Informant's own signature Charles Boswell

(b) Address Evans, Mo.

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof Aug 24  
(Month) (Day) (Year)

(c) Place: burial or cremation Douglas, Mo.

18. (a) Signature of funeral director Sparkwood Co.

(b) Address Evans, Mo.

19. (a) 7/24/40  
(Date received local registrar)

(b) C. H. Pearson  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 31 year 1940 hour \_\_\_\_\_ minute 8:30 AM.

21. I hereby certify that I attended the deceased from June 27 to July 31, 1940  
that I last saw him alive on July 21, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death

Hyperstatic Pressure  
Chronic Nephritis  
Hyperstension and High  
Cerebral Hemorrhage

Duration

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

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 exact place) \_\_\_\_\_  
(Specify means of injury) \_\_\_\_\_

28. Signature

L. M. Sheffield (M. D. or other) \_\_\_\_\_  
Address Harwood, Mo. Date signed 7/1/40

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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.....

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 26161

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 772

Primary Registration District No. 4463

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

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

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME John Wesley Boswell

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased Mar 4 1892  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
68 4 27 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 8/3/40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH: Month 7 day 31  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immature cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) (c) Means of injury  
23. Signature [Signature]  
Address \_\_\_\_\_ Date signed 8/26

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

Birmingham Mo 8/26

