

2
3-40
7-39
X23159

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **De Paul Hospital**
(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 **Samuel Boismenu**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mary**

6. (c) Age of husband or wife if alive **70** years

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

8. AGE:

Years	Months	Days	If less than one day
73	6	3	hr. min.

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

10. Usual occupation **Stationary Engineer**

11. Industry or business _____

MOTHER FATHER

12. Name **John Boismenu**

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

14. Maiden name **Margaret La Valley**

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

16. (a) Informant **Mrs Ollie Dossinger**

(b) Address **5844 Highland Avenue**

17. (a) **Burial** (b) Date thereof **Sept. 16, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter & Paul**

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

(b) Address **1225 Union Bldg**

19. (a) **SEP 14 1940** (b) **J. P. ...**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **Ferguson** **NR**
(If outside city or town limits, write "RURAL")

(d) Street No. **Route 10 Box 569**
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **13**
year **1940** hour **7** minute **A.** M.

21. I hereby certify that I attended the deceased from **7-11-40**
_____, 19____, to **7-13-1940**
that I last saw him alive on **7-12-1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Incurable Hernia**
Due to **(Incurable Hernia)**

Due to **Terminal Pulmonary Edema**
Other conditions **(Include pregnancy within 3 months of death)**

Major findings: **Interfering Obstruction of Incurable Hernia**

Of autopsy _____

Duration **3 days**

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 _____

Signature **J. W. ...** (M, D, or other) _____

Address **4952 ...** Date signed **9-15-40**

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

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..... *Bernard A. Stuart*

Licensed Embalmer No..... *3500*

P. O. Address..... *1225 Union, Pa.*

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, fact should be so stated above.