

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 12 1944
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39538
State File No. _____
11943
Registrar's No. _____

Registration District No. _____ Primary Registration District No. **1003**

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: **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 **EDWARD J. BOLAND**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced, **widow**
6. (b) Name of husband or wife **Mary Boland (Gorman)** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **June 28th 1860**
(Month) (Day) (Year)

8. AGE: Years **83** Months **6** Days **2** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Retired**

11. Industry or business **James Boland**

12. Name **Ireland** 13. Birthplace **Ireland** (City, town, or county) (State or foreign country)

14. Maiden name **Mary Conlon** 15. Birthplace **Ireland** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Elizabeth Seidentop**

(b) Address **5006a Northland Avenue**

17. (a) **burial** (Burial, cremation, or removal) (b) Date thereof **1-3-1944** (Month) (Day) (Year)

(c) Place: burial or cremation **Interment Calvary Cen.**

18. (a) Signature of funeral director **Sullivan Brothers,**

(b) Address **2842 North Euclid Avenue,**
St. Louis 31 1943

19. (a) _____ (b) **J. J. Burdick** (Registrar's signature)
(Data received local registrar)

2. USUAL RESIDENCE OF DECEASED: **000 12 96**
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **5006a Northland Avenue** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **30th**
year **1943** hour **4:30** minute **A. M.**

21. I hereby certify that I attended the deceased from **Dec 18 1943** to **Dec 30 1943**
that I last saw him alive on **Dec 29 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Lobar Pneumonia**

Due to **Callosclerosis**

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)
(e) Means of injury _____
23. Signature **W. W. White** (M. D. or other) _____
J. J. Burdick Date signed **1-3-44**

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

MOTHER FATHER

Dr. W. H. White)
or
Dr. E. Kane) at De Paul Hospital

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 I. Mayfield*
Albert I. Mayfield # 3077
Licensed Embalmer No.....
P. O. Address *St. Louis, Missouri.*

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.