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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 16 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8626  
Registrar's No. 5

Registration District No. 363 Primary Registration District No. 6236

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

1. PLACE OF DEATH:  
(a) County Warren  
(b) City or town Marthasville Mo Rural Charlotte  
(c) Name of hospital or institution: 1  
(d) Length of stay: In hospital or institution  
In this community all her life

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Warren  
(c) City or town Marthasville Mo Rural  
(d) Street No. 3 miles South  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME MARY ANN BOEKE

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased Dec 28 1878  
(Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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

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

12. Name Fred Boeke

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

14. Maiden name Elsa Borgman

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

16. (a) Informant Le Noble Osterwald

(b) Address Marthasville Mo

17. (a) \_\_\_\_\_ (b) Date thereof Feb 2 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marthasville Mo

18. (a) Signature of funeral director Fred Whichtenberg

(b) Address Marthasville Mo

19. (a) Feb 1, 1944 (b) Ethel Rehr  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30th  
year 1944 hour 5 minute 20 p.M.

21. I hereby certify that I attended the deceased from Jan 3  
1944 to Jan 30 1944  
that I last saw him alive on Jan 30 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Gastric cancer of stomach

Duration 1 yr  
2 yr  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chr Nephritis  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations H&E  
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) (b) Means of injury 0

23. Signature H C Johnson (M. D. or other) \_\_\_\_\_

Address Marthasville Mo Date signed 1/28/44

1243

45344

**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 *Ired W. Lichtenberg*

Licensed Embalmer No. *1329*

P. O. Address *Merthasville, Mo.*

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

8626

Registration District No.

363

Primary Registration District No.

6226

Registrar's No.

5

## 1. PLACE OF DEATH:

(a) County Warren  
 (b) City or town Rural Charcott, Ind.  
 (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 Mary Ann Boeke

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

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
 race \_\_\_\_\_

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

7. Birth date of deceased Dec 28 1915  
 (Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation none11. Industry or business none

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) 3-17-'44 (b) Ethel Kehr  
 (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration

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 type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

3482 Kohn