

S. No. 4-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18206

State File No. \_\_\_\_\_

FILED JUN 8 1944

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 142

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Independence Sanitarium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 weeks  
(Specify whether  
In this community 11 weeks  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 7  
(c) City or town \_\_\_\_\_  
(If outside the city or town limits, write "RURAL")  
(d) Street No. Rd 1 Rockville mo  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Thomas Leonard Boch

3. (b) If veteran, name war NO 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Jessie Boch 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased August 22 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 8 14 hr. min.

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

10. Usual occupation Farmer

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

12. Name Peter Boch

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

14. Maiden name Martha Biokeft

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

16. (a) Informant Jessie Boch

(b) Address Rd 1 Rockville mo

17. (a) Removal (b) Date thereof May 7-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jaberville mo

18. (a) Signature of funeral director J W Wagner  
(b) Address Kansas city mo

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6  
year 1944 hour 10 minute 30 P.

21. I hereby certify that I attended the deceased from Feb 14  
1944 to May 6 1944  
that I last saw him alive on May 6 and that death occurred on the date and hour stated above.

Immediate cause of death Gonorrhea bladder infection  
Due to tumor of prostatic gland with obstruction  
Due to removal of prostate gland March 1944  
Other conditions Mar 30 1944  
(Include pregnancy within 3 months of death)

Major findings: Large obstructing prostate gland with growth along bladder  
Of operation Large obstructing prostate gland  
Of autopsy Large obstructing prostate gland

22. If death was due to external causes, fill in the following:  
(a) - Accident, suicide, or homicide (specify) 12262  
(b) Date of occurrence \_\_\_\_\_

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?  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature Joseph P. Brown (M. D. or other) \_\_\_\_\_  
Address Independence Mo Date signed May 7 1944

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1163

(Licensed Embalmer's Statement on Reverse Side)

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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.....

*Wm R. Haunschild*

Licensed Embalmer No.....

*4159*

P. O. Address.....

*Kansas City*

**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.**

Registration District No. 146

Primary Registration District No. 2026

1. PLACE OF DEATH:  
(a) County Johnson  
(b) City or town Independence  
(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 Thomas S. Borch  
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.....  
7. Birth date of deceased Aug 22 1903  
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 1 If less than one day..... 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) 5/7/1944 (Date received local registrar) James Russell (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 May day 19 year 1944 hour 11 minute 00 M.  
21. I hereby certify that I attended the deceased from....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate 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) (e) Means of injury.....  
23. Signature..... (M. D. or other) Address..... Date signed.....

SUPPLEMENTARY

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

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

18206