24548

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19497

FILED JUN 23 1944 318 1003

Registration District No. ____ Primary Registration District No. ____ Registrar's No. 5343

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

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: St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 days (Specify whether years, months or days)

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1813 S. 11th st
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME Myrtle Bossee

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Eddie Bosse

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

7. Birth date of deceased July (Month) 8 (Day) 1887 (Year)

8. AGE: Years 56 Months 11 Days 1 If less than one day ____ hr. ____ min.

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

10. Usual occupation housework

11. Industry or business none

MOTHER FATHER

12. Name Charles W. Price

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

14. Maiden name Mary Whitehead

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

16. (a) Informant Charles M. Price

(b) Address 2616 N. Garrison ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 13-44 (Month) (Day) (Year)

(c) Place: burial or cremation St. Mathews Cemetery

18. (a) Signature of funeral director A. Kron & U. Co.

(b) Address 2707 N. Grand Blv'd

19. (a) JUN 12 1944 (Date received local registrar) (b) J. F. Budesa (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9th year 1944 hour 8 minute 40 A M.

21. I hereby certify that I attended the deceased from May 16th, 1944, to June 9th, 1944 that I last saw her alive on June 9th, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Terminal pneumonia	
Due to: Pericarditis	
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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature Neil Wade (M. D. or other)

Address 1515 Lafayette Date signed 6/9/44

1944 8 U4

(Licensed Embalmer's Statement on Reverse Side)

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 V E Morris

Licensed Embalmer No. 3360

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.