

S. No. 2  
M-8-43  
v. 5-17-39  
-I X37823

35684

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED DEC 9 1944  
318

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 10236

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:  
City Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 22 hours  
In this community 64 years  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1413 Madison St.  
(If rural, give location)  
(e) Citizen of foreign country? 0  
If yes, name country \_\_\_\_\_ (Yes or No)

3. (a) PRINT FULL NAME Mrs. Floria Boswell

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

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

6. (b) Name of husband or wife Fred Boswell  
6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased May 13th. 1880  
(Month) (Day) (Year)

8. AGE: 64 Years 6 Months 16 Days  
If less than one day hr. min.

9. Birthplace Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Mr. Fred Boswell

(b) Address 1413 Madison St.

17. (a) Burial (b) Date thereof 12-2-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Hy. Leidner U. Co.  
(b) Address 2223 St. Louis Ave.

19. (a) DEC 1 (b) 1944  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 29th.  
year 1944 hour 9 minute 25 AM

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

Immediate cause of death Lobar pneumonia  
Cardiac failure  
Acute

Due to \_\_\_\_\_  
Due to 108  
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) (c) Means of injury \_\_\_\_\_  
23. Signature Alfred J. Perry (M.D. or other) \_\_\_\_\_  
Date signed 12/2/44

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

MOTHER FATHER

**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 *J. W. Wilkinson*  
Licensed Embalmer No. 3575  
P. O. Address.....

**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.**