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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 25 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 69

Registrar's No. 405

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

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:
1387 Hamilton Ave.,
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 76

(d) Street No. 1387 Hamilton Ave.,
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William A. Boschert.

3. (b) If veteran, name war No

3. (c) Social Security No. 493-07-3383.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife Louise Boschert

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased May 28, 1882.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
62	7	16	hr. min.

9. Birthplace St. Louis, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business

FATHER
12. Name Alous Boschert
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Frances Bentz
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Louise Boschert
(b) Address 1387 Hamilton Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17/45.
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.,

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.,

19. (a) JAN 15 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13
year 1945 hour 6.00 minute P.M. M.

21. I hereby certify that I attended the deceased from 1/30/41, 19 , to Jan 13, 1945
that I last saw him alive on 1 month ago, 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion repeated attacks sense	1/30/41
Due to: Coronary sclerosis	
Due to:	
Other conditions: none (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

94

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 Chas W Miller (M.D. or other)
Address 408 Humboldt Bldg Date signed 1/18/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Charles Miller
408 Humboldt Bldg.,
12-3 P.M.
JE. 4980.

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. By 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.