

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

20296

State File No.

**NO JUL 12 1945**

Registration District No.

Primary Registration District No. 4190

Registrar's No. 132

1. PLACE OF DEATH:

(a) County Gasconade  
(b) City or town Bland  
(c) Name of hospital or institution: Residence  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 44 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Christian August Boesch

3. (b) If veteran, name war no 3. (c) Social Security No. 499-03-9973

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Rose Boesch 6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased Aug 4 1875 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 10 26 hr. min.

9. Birthplace Swiss MO. D  
(City, town, or county) (State or foreign country)

10. Usual occupation Building Contractor

11. Industry or business Construction

12. Name Jacob Boesch  
13. Birthplace Switzerland 5  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Drewell  
15. Birthplace Holland  
(City, town, or county) (State or foreign country)

16. (a) Informant Maurice Boesch  
(b) Address Belle, MO

17. (a) Burial (b) Date thereof 7-2-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cem. Bland MO

18. (a) Signature of funeral director Sassmann Funeral Home

(b) Address Bland MO

19. (a) July 22 1945 (b) Myrtle M. Warkel  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Gasconade  
(c) City or town Bland 37  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 30  
year 1945 hour 5 minute 2 M.

21. I hereby certify that I attended the deceased from 1-3-  
1944 to 6-30, 1945  
that I last saw him alive on 6-20, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 922

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 0

23. Signature B. J. Bunge (M. D. or other)  
Address 132 and 2nd Date signed 6-30-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1081 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed 7-11-45

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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

Robert M. Murray  
3749

Licensed Embalmer No. \_\_\_\_\_

P. O. Address

Owensville, 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.