. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 25 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21159

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1605

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 355 days (Specify whether
In this community 5 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County —
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1028 Vandeventer
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME BOLES, SHELBY F.
3. (b) If veteran, name war
3. (c) Social Security No. 427-16-8672
4. Sex male
5. Color or race negro
6. (a) Single, widowed, married divorced married
6. (b) Name of husband or wife Sammie Davidson
6. (c) Age of husband or wife if alive 41 years
7. Birth date of deceased July (Month) 2 (Day) 1904 (Year)

8. AGE:	Years	Months	Days	If less than one day
	40	11	15	hr. min.

9. Birthplace Oxford (City, town, or county) Miss (State or foreign country)
10. Usual occupation Shoemaker
11. Industry or business Self
FATHER
12. Name W. R. Boles
13. Birthplace Oxford (City, town, or county) Miss (State or foreign country)
MOTHER
14. Maiden name Rosie Taylor
15. Birthplace Oxford (City, town, or county) Miss (State or foreign country)
16. (a) Informant Hospital record
(b) Address Robert Koch Hosp - Koch - Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-21-45 (Month) (Day) (Year)
(c) Place: burial or cremation Batesville, Miss.
18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Ave.
19. (a) (Date received local registrar) (b) Dr. E. G. McGovran (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17 year 1945 hour 12 minute 25 P.M.
21. I hereby certify that I attended the deceased from 6-27, 1944, to 6-17, 1945; that I last saw him alive on 6-17, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Blood transfusion	
Due to Thoracoplasty	
Due to Pulmonary Tuberculosis	2 yrs
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Pulmonary Tuberculosis	

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 Samuel S. Ranardick (M. D. or other)
Address Koch Hosp. - Koch, Mo Date signed 6/18/45

(Licensed Embalmer's Statement on Reverse Side)

JUL 10 1946

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

Thomas J. Gates, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Ave.

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.