

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **9729**

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:
3803 CASTLEMAN
(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 _____
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **3803 CASTLEMAN AV.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **ALBERT Joseph BOECHER**

3. (b) If veteran, **WORLD WAR ONE** name war _____
3. (c) Social Security No. **498-03-6959**

4. Sex **MALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **/**

6. (b) Name of husband or wife **KATHERINE Boecher**
6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **APRIL 28 - 1898**
(Month) (Day) (Year)

8. AGE: Years **48** Months **6** Days **16**
If less than one day _____ hr. _____ min.

9. Birthplace **ST. LOUIS Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **MAINTENANCE**

11. Industry or business **ANHEUSER-BUSCH**

12. Name **FRED BOECHER**

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

14. Maiden name **LENA BRINKMAN**

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

16. (a) Informant **Mrs. Katherine Boecher**

(b) Address **3803 Castleman Av.**

17. (a) **BURIAL** (b) Date thereof **NOV 16 - 46**
(Burial, cremation or entombment) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem.**

18. (a) Signature of funeral director **E. J. Schurer**
(b) Address **3125 Lafayette**

19. (a) **NOV 15 1946** (b) **J. T. Bredeek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **14**
year **1946** hour **6** minute **30 A. M.**

21. I hereby certify that I attended the deceased from **11-14**, 1946, to **11-14**, 1946;
that I last saw him... alive on **11-14**, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
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 _____

23. Signature **Harold Steele** (M. D. or other) _____
Address **1700-a Tower Grove Ave.** Date signed **11-14-46**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Licensed Embalmer No.....

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.