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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **42156**
 Registrar's No. **11206**

FILED JAN 7 1947
 318

Registration District No. _____ Primary Registration District No. **1003**

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:
5060 Claxton
(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)

3. (a) PRINT FULL NAME Mamie A. Boheim
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex F / 5. Color or race W
 6. (a) Single, widowed, married, divorced M /
 6. (b) Name of husband or wife Anton
 6. (c) Age of husband or wife if alive 71 years
 7. Birth date of deceased Nov. 19 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 1 8 _____ hr. _____ min.

9. Birthplace Zarnesville Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER { 12. Name John Draper
 13. Birthplace Illinois
(City, town, or county) (State or foreign country)
 14. Maiden name Sarah E. Michaels
 15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Anton Boheim

(b) Address 5060 Claxton

17. (a) ~~Funeral~~ Removed (b) Date thereof 12/30/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakwood Cemetery, Alton

18. (a) Signature of funeral director Provost Und. Co. Ill

(b) Address 3710 N. Grand Blvd.

19. (a) DEC 30 1946 (b) J. F. Brebeck
(Date received for final registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 5060 Claxton
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 27
 year 1946 hour 6 minute 30 P.M.
 21. I hereby certify that I attended the deceased from April 15
 19 44 to Dec 27 19 46
 that I last saw her alive on Dec 27 19 46
 and that death occurred on the date and hour stated above.
 Immediate cause of death apoplexy
 Due to general hypertension 3 yrs
 Due to _____
 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) (e) Means of injury _____
 23. Signature R. R. Menoun (M. D. or other) MD
 Address 5330 Geraldine signed 12/28/46

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 W E Morris
Licensed Embalmer No. 3360
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.