

FILED FEB 10 1948
#57825

Registration District No. _____
Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME WILLIAM BOSWELL

3. (b) If veteran, name war Spanish-American No. _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased About 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

About 71 hr. min.

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

10. Usual occupation Nil

11. Industry or business _____

MOTHER { 12. Name Wm. H. Boswell

FATHER { 13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name Louisa Rais Duis

15. Birthplace Louisiana /
(City, town, or county) (State or foreign country)

16. (a) Informant Alfred C. Boswell

(b) Address 822 a Tyler St.

17. (a) Burial (b) Date thereof Feb. 1, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cem.

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.

(b) Address 7814 S. Broadway

19. (a) JAN 31 1948 J. F. Brudeck
(Date received local registrar's report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 0-00

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

(d) Street No. 1413 Madison St.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30th
year 1947 hour 8:05 minute A M.

21. I hereby certify that I attended the deceased from 1/28/47
_____ 19, to 1/30/47 19, _____ 19,
that I last saw him alive on 1/30/47 19, _____ 19,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Meningitis - Purulent -
Organism not grown
Microbiologically

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

Major findings: _____

Of operations _____

Of autops: As above

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? _____

23. Signatures _____
(Specify type of place) (e) Means of injury

1515 Lafayette 1/30/47 (other) _____
Address Date signed

Emb separate Cert filed

JAN 31 1947

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.