V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6045

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1343

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: Firman-Desloge Hospital (If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 1317

(d) Street No. 5433 Reber Place (If rural, give location) 9

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Jacob T. Boultas (Bultas)

3. (b) If veteran, name war *****

3. (c) Social Security No. 291-12-5980

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Myra Boultas

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased February 16 1888 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
58	11	20	hr. min.

9. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation Maintainance Man

11. Industry or business American Stove Co

FATHER
12. Name Thomas Boultas
13. Birthplace Germany (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Katherine Siebert
15. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

16. (a) Informant Myra Boultas

(b) Address 5433 Reber Place

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-1947 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Ziegenhein Bros.

(b) Address 6409 Gravois Ave

19. (a) FEB 10 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6th day February year 1947 hour 5:00 minute P. M.

21. I hereby certify that I attended the deceased from 1/28/47, 19 , to 2/6, 1947; that I last saw him alive on 2/6, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Brain Tumor	2-3 mos.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Brain Tumor (Glioma)

Of autopsy Brain Tumor

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 0

23. Signature Edmund A. Smith MSD (M. D. or other)

Address Beaumont Bldg Date signed 2/8/47

(Licensed Embalmer's Statement on Reverse Side)

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.....Homer W. Fritz.....

Licensed Embalmer No.....3882.....

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.