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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAY 29 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 18635

Registrar's No. 5056

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: 1923 Sullivan Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 61 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1923 Sullivan Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mr. Fred Boversmith.
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Katie Boversmith.
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased January 22nd. 1886 (Month) (Day) (Year)

8. AGE: Years 61 Months 4 Days 26 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Street & Sewer Dept.
11. Industry or business City of St. Louis
FATHER
12. Name Fred Boversmith.
13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name Anna Sweppe
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Mrs. Katie Boversmith.
(b) Address 1923. Sullivan Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-21-47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Hy. Leidner U. Co.
(b) Address 2223 St. Louis Ave.
19. (a) MAY 20 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18th. year 1947 hour 12 noon minute M.

21. I hereby certify that I attended the deceased from July 1- 1944 to May 18 1947 that I last saw him alive on May 18 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia poisoning	5 d.
Due to Glomerulonephritis	1 yr
Due to	
Other conditions Rectal cancer operated 3 yrs ago. Possible relapse (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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 L. C. Crearne (M. D. or other) M.D.
Address 2504 N 18th St Date signed 5-19-47

Jefferson City Printing Co.

(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 John P. Buchholz

Licensed Embalmer No. 1674

P. O. Address 2223 St. Louis

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.