

S. No. 2
1-12-45
5-17-39
I X47070

FILED SEP 3 1947

Registration District No. **3/1**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Overland**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
8129 St. Charles Lane, Home. ✓
(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)

3. (a) PRINT FULL NAME **Augustina Boggiano**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Female** **5. Color or race** **White**

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

6. (b) Name of husband or wife **Angelo M. Boggiano**

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

7. Birth date of deceased **Feb. 18 1859**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day hr. min.
	88	6	8	

9. Birthplace **Italy** 5
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business

12. Name **Cella**

13. Birthplace **Italy** 5
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Italy** 5
(City, town, or county) (State or foreign country)

16. (a) Informant **Stephen L. Boggiano**

(b) Address **8129 St. Charles Lane**

17. (a) Burial (b) Date thereof **Aug. 29/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Mausbleum**

18. (a) Signature of funeral director **Jos. W. Clark**

(b) Address **1125 Hodiamont Ave**

19. (a) 8-28-47 (b) **Beula J. [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis** 96

(c) City or town **Overland** 12
(If outside city or town limits, write "RURAL")

(d) Street No. **8129 St. Charles Lane** 1
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **26**
year **1947** hour **8** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **Aug 24**, 1947 to **Aug 26**, 1947;
that I last saw him or alive on **Aug 26**, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic nephritis
Acute Myo Carditis

Due to **1316**

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

Major findings:
Of operations _____

Of autopsy **no**

Duration _____

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 **Dr. Schussach** (M. D. or other) _____
Address **8816 - St. Charles Rd.** Date signed **Aug 27 47**

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

Dr. Schumacher N. A.
8816A St. Charles Rock Rd.
Webash 1350

JUN 6 1957

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 Alfred J. Boedecker
Licensed Embalmer No. 2663

P. O. Address 1125 Hodiament Ave.

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.