

No. 300  
1-10-47  
5-17-39  
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MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 33940  
Registrar's No. 8703

Registration District No. 318

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution 5385 Easton Ave.  
(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 Walter W Boeck

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 Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased SEPT. 30 1948  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation none

11. Industry or business none

12. Name Walter Boeck

13. Birthplace Peoria, Ill. (City, town, or county) (State or foreign country)

14. Maiden name Rose Marshall

15. Birthplace Pinolewn, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Walter Boeck

(b) Address 5385 Eason Ave.

17. (a) Burial (Burial, cremation, or removal) Floral Park, Mo.

(b) Date thereof Oct. 7, 1948 (Month) (Day) (Year)

18. (a) Signature of funeral director J. B. Laster

(b) Address 1259 Union Blv.

19. (a) OCT 6 1948 (Date received local registrar)

(b) J. B. Laster (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Louis

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

(d) Street No. 5385 Easton Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6 year 1948 hour 12:30 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Sept 30 48 \_\_\_\_\_, 19\_\_\_\_, to Oct 6 \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

that I last saw him alive on Oct 6 \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Premature Sick

Due to cardiac insufficiency

Due to bronchial hemorrhage

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 A. R. Schumacher (M. D. or other) \_\_\_\_\_

Address 8816 St. Charles Date signed Oct 6 48

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**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 Ms embalming

Licensed Embalmer No.....

P.O. Address J. M. Lewis

**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.**