

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39798

State File No. _____

FILED JAN 8 1949

Registration District No. 119

Primary Registration District No. 4193

Registrar's No. 31

1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Hermann
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1008 Washington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

3. (a) PRINTED FULL NAME William Arnold Henry Boening

3. (b) If veteran, name war ----- 3. (c) Social Security No. 488-26-0149

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Agnes Boening 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Dec 25 1888
(Month) (Day) (Year)

8. AGE: Years 59 Months 11 Days 11 If less than one day hr. min.

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

10. Usual occupation Merchant

11. Industry or business

12. Name William Boening
13. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)
14. Maiden name Emily Blazer
15. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Theo. Boening
(b) Address St. Louis Mo

17. (a) Removal (b) Date thereof 12-7-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis Mo

18. (a) Signature of funeral director Nugost
(b) Address Hermann Mo

19. (a) 12/7/48 (b) W. M. M. W. W. W.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 7236 St. Charles Rock Rd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 6
year 1948 hour 2:45 minute 1 M.

21. I hereby certify that I attended the deceased from 12-6-48
to 12-6-48
that I last saw him alive on 12-6-48
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Cerebral Arteriosclerosis
general

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

Major findings:
Of operations _____
Of autopsy 830

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)
(r) Means of injury _____

23. Signature W. M. M. W. W. (M. D. or other) M.D.
Address 508 N. Grand Date signed 12-6-48

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number
JAN 6 1949
Date Filed

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. 3160

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.