



Dr. J. F. Hutcherson,  
1502 Union Blvd.,  
Po. 1430

11<sup>30</sup> am - Wed.

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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

*John A. Miller*

Licensed Embalmer No. *4186*

P. O. Address

*St. Louis, Mo.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF VITAL STATISTICS

State of Missouri  
County of St. Louis ) ss.

State File No. 42045-48  
Local Registrar's No. ....

**AFFIDAVIT FOR CORRECTION OF A RECORD**

On this 9th. day of May, 1949, before me appears.....

Dr. L.F. Hutcherson, who, upon his oath, states that the original record of ~~birth~~ death  
for Andrew J. Boedeker <sup>died</sup> ~~born~~ Dec 10, 1948, in the State of  
Missouri, and which was filed at Clayton on Dec 8, 1948, should be corrected as follows:

Item No. 20 should read December 8 1948 hour 6 A M

Instead of December 10 1948 hour 6 A M

Item No. .... should read.....

Instead of.....

The above is true to the best of my knowledge, information and belief.

(SEAL)

Dr. L.F. Hutcherson  
1502 1/2 Union  
St. Louis, Mo.

Affiant.

Maybelle Boedeker Wife  
Relationship.

8606 Alden Avenue  
Present Address.

Subscribed and sworn to before me this 9th. day of May, 1949

My Commission expires

Dec 18 1950 [Signature]

Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.



THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 2834

Registration District No. 317 Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Charleston Heights  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
8606 Olden Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
-In this community..... years, months or days)

3. (a) PRINT FULL NAME Andrew J. Boldtke  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color of race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased April 20  
(Month) (Day) (Year)

8. AGE: Years 64 Months 0 Days 0 (If less than one day, hr. min.)

9. Birthplace No  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town Charleston Heights  
(If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 10 Year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to.....  
that I last saw him..... alive on..... and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

Due to.....

Due to.....

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..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

(52) 42045