

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 8 1952

318

PRIMARY REG. DIST. NO. 1003 Registrar's No. 11773

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11773	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS CO.</u>		d. STREET ADDRESS <u>320 BRAND</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1</u>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>JAMES</u>		b. (Middle) <u>E.</u>		c. (Last) <u>BOSLER</u>	
4. DATE OF DEATH		(Month) <u>DEC.</u>		(Day) <u>31,</u>		(Year) <u>1951</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>FEB. 13 1950</u>	
9. AGE (In years last birthday) <u>1</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ERNEST BOSLER</u>		13b. MOTHER'S MAIDEN NAME <u>SHIRLEY MESCHER</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>JAMES THOMAS 320 BRAND</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hydrocephalus</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Tuberculous Meningitis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Hydrocephalus, Tuberculous Meningitis, Pulmonary Tbc</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) _____		21d. (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>MOBK</u>			
22. I hereby certify that I attended the deceased from <u>9-15-51</u> , 19____, to <u>12-31-51</u> , 19____, that I last saw the deceased alive on <u>12-31-51</u> , 19____, and that death occurred at <u>11:35Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Donald L. Smith M.D.</u>				23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>1-2-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>JAN. 3 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>JAN 3 1952</u>		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutis 2906 Florio</u>			

Licensed Embalmer's Statement on Reverse Side)

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

APR 9 1952

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *Walter C. Dill*

Signed.....
Student Embalmer

Licensed Embalmer No. *43471*

P. O. Address *2906 Travis*

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.