

No. 300
10. 48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14070**
3466
Registrar's No.

FILED APR 25 1952

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 14070		Registrar's No. 3466		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Alexander						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN TAMMA			8720			
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Pacific Hospital				d. STREET ADDRESS (If rural, give location) P.O. Box # 84						
3. NAME OF DECEASED (Type or Print) a. (First) George			b. (Middle) Isaac		c. (Last) Boswell		4. DATE OF DEATH (Month) (Day) (Year) April 11 1952			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH August 4, 1879		9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector			10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME John Boswell			13b. MOTHER'S MAIDEN NAME Florence Hedge			14. NAME OF HUSBAND OR WIFE Louisa Boswell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) Nil		17. INFORMANT'S SIGNATURE OR NAME John Boswell		ADDRESS 5617 Hollows-East St.				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic cardiac decompensation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular Disease 6 yrs. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Gastrointestinal hemorrhage 3 days						INTERVAL BETWEEN ONSET AND DEATH 6 months		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____ (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____				
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H221								
22. I hereby certify that I attended the deceased from 5/28, 1948 , to 4/11, 1952 , that I last saw the deceased alive on 4/11, 1952 , and that death occurred at 7:00 p.m. , from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) [Signature]				23b. ADDRESS [Address]			23c. DATE SIGNED 4-12-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-12-52		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Mounds, Illinois				
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 12 1952 [Signature]				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe-4700 Washington Blvd						

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John S. Kennedy

Licensed Embalmer No. *41940*

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.