

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30608**
Registrar's No. **8213**

FILED SEP 29 1955

REG. DIST. NO. **318**

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

BIRTH NO. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 7	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If rural, give location) 26 2823 N 19th	
3. NAME OF DECEASED (Type or Print) a. (First) MABEL b. (Middle) c. (Last) BOEHLAU		4. DATE OF DEATH (Month) (Day) (Year) 9 18 55	
5. SEX F	6. COLOR OR RACE W	7. MARRIED—NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED Widow	8. DATE OF BIRTH 10.6.82
9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 12 Hrs. Hours
IF UNDER 12 Hrs. Min.	10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (City and State or Foreign Country) LAFAYETTE IND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Alpheus Booher		13b. MOTHER'S MAIDEN NAME MARY Thomas	14. NAME OF HUSBAND OR WIFE Otto
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 493-07-5050	17. INFORMANT'S SIGNATURE OR NAME ADDRESS W.O.Fry, Ashley, Ill.	
MEDICAL CERTIFICATION			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident - Embolus	
		INTERVAL BETWEEN ONSET AND DEATH 5 days	
		ANTECEDENT CAUSES DUE TO (b) Arricular Fibrillation 3 1/2 yrs	
		DUE TO (c) Arteriosclerotic Heart Disease 3 1/2 yrs +	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia 10 days	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 420.0		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?	
22. I hereby certify that I attended the deceased from 9/13/55 , 19—, to 9/18 , 19 55 , that I last saw the deceased alive on 9/17 , 19 55 , and that death occurred at 2:45 A m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Robert C Drews M.D.		23b. ADDRESS St. Lukes Hosp, St Louis Mo.	23c. DATE SIGNED 9/18/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-18-55	24c. NAME OF CEMETERY OR CREMATORY Kirk Cemetery	24d. LOCATION (City, town, or county) (State) Ina, Ill.
DATE REC'D BY LOCAL REG. SEP 19 1955	REGISTRAR'S SIGNATURE J. Earl Smith MO	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 J. Haines

Licensed Embalmer No. 4108

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.