

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **31861**

FILED OCT 8 - 1955

BIRTH NO. _____		REG. DIST. NO. <b>317</b>		PRIMARY REG. DIST. NO. <b>590</b>		Registrar's No. <b>2198</b>			
1. PLACE OF DEATH a. COUNTY <b>St Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pulaski</b>					
b. CITY OR TOWN <b>Valley</b>		c. LENGTH OF STAY (In this place) <b>5 yrs</b>		c. CITY OR TOWN <b>Dixon</b>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mounted Route</b>				STREET ADDRESS (If rural, give location) <b>8 miles east of Dixon</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Martha</b>		b. (Middle) <b>Elizabeth</b>		c. (Last) <b>Boulware</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Sept 20 1955</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Feb 1 1870</b>			
9. AGE (In years last birthday) <b>85</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Houseswife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Riley Duncan</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Ragen</b>		14. NAME OF HUSBAND OR WIFE <b>Vard Boulware</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Pearl Spielhagen</b> ADDRESS <b>Valley Park, Mo.</b>					
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinomatosis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Ca of the stomach</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>A.S.C.V. Disease.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>151x</b>				20. AUTOPSY? YES <input 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) (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WRITE 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 <b>June 1954</b> , to <b>Sept 20, 1955</b> , that I last saw the deceased alive on <b>Sept 19, 1955</b> , and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Frank Huck M.D.</b>				23b. ADDRESS <b>Fenton, Mo.</b>		23c. DATE SIGNED <b>9/21/55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Sept 23, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>		24d. LOCATION (City, town, or county) (State) <b>Marion Co. Mo.</b>			
DATE REC'D BY LOCAL REG. <b>9-21-55</b>		REGISTRAR'S SIGNATURE <b>Berbert R. Domb</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Leon H. Eide Fenton, Mo.</b>					

5.6. (Licensed Embalmer's Statement on Reverse Side)

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

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Daniel J. Mahoney*

Licensed Embalmer No. *1234*

P. O. Address *Hele...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.