

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44341

State File No. ....

FILED DEC 20 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 319 PRIMARY REG. DIST. NO. 500 Registrar's No. 2855

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St Louis</u> b. CITY (If outside corporate limits, write RURAL and give town or township) OR TOWN <u>Woodson Terrace</u> c. LENGTH OF STAY (in this place) <u>1 wk</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>9255 Leith</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Woodson Terrace</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>9255 Leith</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Margaret Boland</u> a. (First) b. (Middle) c. (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec 3 1956</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Nov 26 1956</u>
<b>9. AGE</b> (In years last birthday) <u>53</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 14 HRS: Hours _____ Min. _____		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) / <u>Springfield Ohio</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13a. FATHER'S NAME</b> <u>John Duffy</u>	
<b>13b. MOTHER'S MAIDEN NAME</b> <u>Bridget Hesson</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Paul Boland</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>491-12-8361</u>	
<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Paul Boland</u>		<b>ADDRESS</b> <u>9255 Leith</u>	
<b>18. CAUSE OF DEATH</b> 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.		<b>MEDICAL CERTIFICATION</b> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma, chest and abdomen</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma 1 Stomach</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____	
<b>19a. DATE OF OPERATION</b> _____		<b>19b. MAJOR FINDINGS OF OPERATION</b> _____	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>151X</b>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) _____		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> _____		<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (m.) _____	
<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> _____	
<b>22. I hereby certify that I attended the deceased from</b> <u>Dec 2, 1956</u> , to <u>Dec. 3, 1956</u> , that I last saw the deceased alive on <u>Dec 2, 1956</u> , and that death occurred at <u>3:45 A.M.</u> , from the causes and on the date stated above.			
<b>23a. SIGNATURE</b> <u>John S. Dwyer</u>		<b>23b. ADDRESS</b> <u>1101 D. Creve Coeur, Mo</u>	
<b>23c. DATE SIGNED</b> <u>12/3/56</u>		<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>	
<b>24b. DATE</b> <u>12/5/56</u>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>Calvary Cemetery</u>	
<b>24d. LOCATION</b> (City, town, or county) (State) <u>St Louis Mo</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ortmann F Home</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>12-4-56</u>		<b>ADDRESS</b> <u>9222 Lackland Overland Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

Overland Mo

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

No. 300  
10-48

**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 *W. C. Oetmann*.....

Licensed Embalmer No. *3470*.....

P. O. Address .....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**