

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042789  
STATE FILE NUMBER

FILED DEC 10 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3116

S. 300  
1-57

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1. PLACE OF DEATH a. COUNTY <u>MANCHESTER Mo. ST. Louis Co.</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MANCHESTER Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Manchester 4000</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PINE CREST NURSING HOME</u>		Length of stay in lb <u>2 YRS. 2 Mo</u>	d. STREET ADDRESS (If outside, give location) <u>Manchester Rd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Boedecker</u> Last <u>Boedecker</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>58</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1881</u>	9. AGE (In years last birthday) <u>77 YRS.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>Franklin Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Herman Hostkoetter</u>		13b. MOTHER'S MAIDEN NAME <u>Louise Bockius</u>		14. NAME OF HUSBAND OR WIFE <u>August Boedecker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	17. INFORMANT Address <u>St. Louis Mo.</u> <u>Ray Hostkoetter 6426 St. Louis Ave.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Cerebral Emboli</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Arteriosclerosis</u>					<u>Don't know</u>
DUE TO (c) <u>Generalized Arteriosclerosis</u>					<u>Don't know</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332X</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT' SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>May 27, 1958</u> to <u>Nov. 26, 58</u> and last saw <u>him</u> alive on <u>Nov. 26, 1958</u> Death occurred at <u>4:45 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ralph W. Laffey, M.D.</u>			22b. ADDRESS <u>Box 122, Manchester, Mo.</u>		22c. DATE SIGNED <u>11-28-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-1-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Ballwin, Mo.</u>
24. FUNERAL DIRECTOR <u>Schrader Funeral Home Ballwin Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>11-28-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert B. Dombek</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Richard Bopp* .....

Licensed Embalmer No. *4584* .....

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