

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010718

STATE FILE NUMBER

2477

MAR 30 1959

Registration District No.

Primary Registration District No.

Registrar No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FLOISSANT 405</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>CHRISTIAN Hosp.</u>		Length of stay in 1b <u>15 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>815 N. FLOISSANT RD.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>J.</u> Last <u>BOEGEMANN</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>9</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 8, 1884</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13a. FATHER'S NAME <u>JOHN BOEGEMANN</u>		13b. MOTHER'S MAIDEN NAME <u>CATHERINE SILLS</u>		14. NAME OF HUSBAND OR WIFE <u>DECEASED.</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>443-42-6464</u>		17. INFORMANT <u>FRANK BERGANS, 11259 OLD HALLS FERRY FLOISSANT, MO.</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>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Multiple Arterial Emboli</u> DUE TO (c) <u>Arterio Sclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420-0</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>7 days</u> <u>Chronic</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>420-0</u>		
20c. TIME OF INJURY Hour a.m. Month, Day, Year 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>Feb 21, 1959</u> to <u>Feb 29, 1959</u> and last saw him alive on <u>March 9, 1959</u> Death occurred at <u>10:45 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R. J. O'Conner</u> (Degree or title)			22b. ADDRESS <u>Floissant, Mo.</u>		22c. DATE SIGNED <u>3-10-59</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3-12-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO.</u>
24. FUNERAL DIRECTOR <u>THE FLOISSANT MORTUARY</u>		ADDRESS <u>FLOISSANT, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 11 '59</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</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 *Gene A. Hutchins*

Licensed Embalmer No. *4966*

P. O. Address *FLORISSANT, 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.