Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-011802
STATE FILE NUMBER

FILED APR 14 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 908

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN Riverview — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 409 Adrian Dr — Length of stay in 1b: 1 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Riverview 4000 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 409 Adrian Dr. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First JOHN Middle FREDERICK Last BOEHMER

4. DATE OF DEATH Month April Day 2nd Year 1959

5. SEX male

6. COLOR OR RACE white

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH February 10th, 1918

9. AGE (In years last birthday) 41 — 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) laborer

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (City and state or country) St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Boehmer

13b. MOTHER'S MAIDEN NAME Mae Schelin

14. NAME OF HUSBAND OR WIFE Rose Boehmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 492-10-5158

17. INFORMANT Rose Boehmer, Address 409 Adrian Dr.,

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarct	7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Acute Bronchitis	0 days
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 3-27-59, to 4-2-59 and last saw her/him alive on 4-1-59
Death occurred at 2 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Nicholas Flynn M.D. (Degree or title)

22b. ADDRESS 3701 N. 25th St.

22c. DATE SIGNED 4-3-59

23a. BURIAL, CREMATION, REMOVAL (Specify) burial

23b. DATE 4/4/59

23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery

23d. LOCATION (City, town, or county) St. Louis Co., Mo. (State)

24. FUNERAL DIRECTOR DIEDRICH FUNERAL HOME, ADDRESS 8319 Hallsferry

25. DATE RECD. BY LOCAL REG. 4-3-59

26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. L.

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.