

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014708

STATE FILE NUMBER

Registration No. **3919**

FILED MAY 6 1959 Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Colorado b. COUNTY Jefferson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Arvada Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Length of stay in lb 6 days	d. STREET ADDRESS (If outside, give location) 5167 Road Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Frank Middle Joseph Last Boehm			4. DATE OF DEATH Month Apr. Day 19, Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1889	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Meat Cutter	10b. KIND OF BUSINESS OR INDUSTRY Meat	11. BIRTHPLACE (City and state or county) Carlinville, Ill.	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Michael Boehm	13b. MOTHER'S MAIDEN NAME Josephine	14. NAME OF HUSBAND OR WIFE Gertrude M. Boehm
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT Mr. Gertrude M. Boehm, Arvada, Colo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Acute myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 6 da
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arterio Sclerotic Hypertensive Heart Disease	
	DUE TO (c) 420.0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <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 _____
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21. I attended the deceased from 14 Apr 59 to 19 Apr 59 and last saw him alive on 18 Apr 59 Death occurred at 2:00 am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Elaine W. Hall, MD	(Degree or title)	22b. ADDRESS 116 So Florissant Rd	22c. DATE SIGNED 20 Apr 59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-22-59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) Normandy, Missouri
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24. FUNERAL DIRECTOR White-Mullen Mortuary, Ferguson, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. APR 21 '59	26. REGISTRAR'S SIGNATURE Neal Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ALL DISEASES IN PART I MUST BE CAUSALLY RELATED

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

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

Licensed Embalmer No.....

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.