

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022705

STATE FILE NUMBER

5331

FILED JUN 19 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

300
-57

18

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>Lemay</u> <u>4860</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>		Length of stay in 1b <u>DOA</u>	d. STREET ADDRESS (If outside, give location) <u>369 Hoffmeister</u>

3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>G.</u> Last <u>Boekenheide</u>			4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1897</u>		9. AGE (In years last birthday) <u>61</u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Southern Neon Sign</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>Christ Boekenheide</u>	13b. MOTHER'S MAIDEN NAME <u>Lena Ringering</u>	14. NAME OF HUSBAND OR WIFE <u>Grace Boekenheide</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>499-12-2901</u>	17. INFORMANT <u>Mrs. Grace Boekenheide</u>	Address <u>369 Hoffmeister</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>acute myocardial infarct</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	<u>420.1</u>
	DUE TO (c) _____	
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.)
---	--

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
---	--	--	------------------------------	--------	-------

21. I attended the deceased from _____ <u>1947</u> to _____ <u>1959</u> and last saw her alive on _____ <u>6-2-59</u> Death occurred at _____ <u>3:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) <u>Edw. Weithman M.D.</u>	22b. ADDRESS <u>5600 S Compton</u>	22c. DATE SIGNED <u>6-3-59</u>
---	---------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>June 5, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
---	----------------------------------	--	--

24. FUNERAL DIRECTOR <u>Math Hermann & Son, Inc. 2161 E. Fair</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 3 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

208 C

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 *Clement McNeary*

Licensed Embalmer No. *3739*.....
P. O. Address *St. Louis*.....

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.