

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022711

STATE FILE NUMBER

FILED JUN 19 1959

Registration District No.

Primary Registration District No.

Registrar *2 4968*

300

1-57

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Mo.</i> b. COUNTY <i>St. Louis</i> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <i>St. Louis</i>                   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <i>AFFTON 4870</i><br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <i>LUTHERAN HOSPITAL</i> |  | Length of stay in 1b  | d. STREET ADDRESS (If outside, give location)<br><i>8012 GRAMOND DR.</i><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

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|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <i>MINNIE</i> Middle <i>E</i> Last <i>BOSWELL</i> |  |  | 4. DATE OF DEATH<br>Month <i>MAY</i> Day <i>20</i> Year <i>1959</i> |  |  |
|--|--|--|---|--|--|

|  |                                  |   |   |   |  |
|--|----------------------------------|---|---|---|--|
| 5. SEX<br><i>FEMALE</i>  | 6. COLOR OR RACE<br><i>WHITE</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>JUNE 19, 1902 56</i>         | 9. AGE (In years last birthday)<br>IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>COOK</i> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>AFFTON SCHOOL</i>   |   | 11. BIRTHPLACE (City and state or country) <i>AFFTON, Mo.</i>     |  |
| 13a. FATHER'S NAME<br><i>HENRY VASEL</i>   |                                  |   | 13b. MOTHER'S MAIDEN NAME<br><i>MINNIE PRUETZEL</i> |   | 14. NAME OF HUSBAND OR WIFE<br><i>ROBERT</i> |

|  |   |   |
|--|---|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>NO</i> | 16. SOCIAL SECURITY NO.<br><i>499-36-9630</i> | 17. INFORMANT Address<br><i>ROBERT BOSWELL 8012 GRAMOND DR.</i> |
|--|---|---|

|   |   |   |               |
|---|---|---|---------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Myocarditis</i> |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i>   |               |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <i>Chronic Hypertension from</i> |   | <i>1 year</i> |
|   | DUE TO (c) <i>Chronic Arteriosclerosis</i>  |   | <i>1 year</i> |
| 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?<br>YES <input checked="" type="checkbox"/> NO <input 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.)<br><i>444X</i> |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>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 *May 14th 1959* to *May 20th 1959* and last saw her alive on *May 20th, 1959*  
Death occurred at *10:30 P. M.* on the date stated above; and to the best of my knowledge, from the causes stated

|   |                                   |                                    |
|---|-----------------------------------|------------------------------------|
| 22a. SIGNATURE<br><i>W. H. Walters M.D.</i> (Degree or title) | 22b. ADDRESS<br><i>3608 Grand</i> | 22c. DATE SIGNED<br><i>5/23/59</i> |
|---|-----------------------------------|------------------------------------|

|   |                               |   |  |
|---|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>REMOVAL</i> | 23b. DATE<br><i>5/25/1959</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ST. LUCAS CEMETERY</i> | 23d. LOCATION (City, town, or country) (State)<br><i>SAPPINGTON, Mo.</i> |
|---|-------------------------------|---|--|

|   |                              |  |
|---|------------------------------|--|
| 24. FUNERAL DIRECTOR<br><i>J L ZIEGENHEIN &amp; SONS 7027 GRAVOIS 5-22-1959</i> | 25. DATE RECD. BY LOCAL REG. | 26. REGISTRAR'S SIGNATURE<br><i>Earl Smith. M.D.</i> |
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**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 *Donald E. Beitz* .....

Licensed Embalmer No. *4803* .....

P. O. Address *1117 Harrison* .....

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.