

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>19 days</b>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexian Brothers Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>3148a Pennsylvania</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle Last <b>BOCHHOLT</b>			4. DATE OF DEATH Month <b>September</b> Day <b>6</b> Year <b>1960</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/3/1902</b>	9. AGE (last birthday) <b>58 years</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brewer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewing</b>	11. BIRTHPLACE (City and state or country) <b>New Baden, Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Boehholt</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Nocke</b>		14. NAME OF HUSBAND OR WIFE <b>Mildred Boehholt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>328-03-2181</b>		17. INFORMANT Address <b>Mildred Boehholt-3148a Pennsylvania</b>	

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) <b>PERITONITIS</b>			<b>48 hours</b>
DUE TO (b) <b>ILEO-PERITONEAL FISTULA</b>			<b>48 hours</b>
DUE TO (c) <b>CARCINOMA OF ESOPHAGUS</b>			<b>1 mo</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>150X</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? 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.) <b>150X</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 **8-19-60** to **9-6-60** and last saw <sup>her</sup>him alive on **9-6-60**  
Death occurred at **10:00** **17** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>William Gillespie MD</i>	(Degree or title)	22b. ADDRESS <b>3720 WASHINGTON</b>	22c. DATE SIGNED <b>9-6-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>Sept 9, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Belleville Illinois</b>
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24. FUNERAL DIRECTOR <b>BUCHHOLZ MORT. - 5967 W. Florissant Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>SEP 7 1960</b>	26. REGISTRAR'S SIGNATURE <i>Coan Smith, M.D.</i>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Harvey Stahl*

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.