

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037014

FILED VS. OCT 17 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2871

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gardenville</u>		Length of stay in 1b <u>2 yrs</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Miller Nursing Home</u>				/Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6005 Michigan</u>	
3. NAME OF DECEASED (Type or print) First <u>Sylvester</u> Middle <u>(Joseph)</u> Last <u>J Boardman</u>				4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1960</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8/13/1887</u>	
				9. AGE (last birthday) <u>73</u>		IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>So. Pac. R.R.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	
13a. FATHER'S NAME <u>Albert Boardman</u>				13b. MOTHER'S MAIDEN NAME <u>Elizabeth Hlidik</u>		14. NAME OF HUSBAND OR WIFE <u>Estell Boardman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War I</u>				16. SOCIAL SECURITY NO. <u>700-09-8719</u>		17. INFORMANT Address <u>Doris Kriege 3441 So. Jefferson Ave.</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>Cerebral Hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cerebrovascular Disease</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)						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	
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.		Month, Day, Year					
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>1958</u> to <u>9/29/60</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>9/28/60</u> Death occurred at <u>2:30</u> <u>p</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Rg H Schmeweiser M.D.</u>				22b. ADDRESS <u>6817 Gravois.</u>		22c. DATE SIGNED <u>9/30/60</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10-1-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hiram Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>E. J. Schnur 3125 Lafayette Ave.</u>				25. DATE RECD. BY LOCAL REG. <u>9-30-60</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R. H. SCHNIE MEIER - 6819 GRANVILLE - 68119 GRANVILLE - FRI-164, VE 2 0433

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Thomas R. Jensen

Licensed Embalmer No. 379

P. O. Address 3125 L

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.