

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025405

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Reg. No. **FILED JUL 9 1962** Primary Registration District No. **500** Registrar's No. **1952** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 4000

2 4000

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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP) OR TOWN <b>Lemay (Mehlville)</b>		Length of stay in 1b <b>YRS.</b>	c. CITY OR TOWN <b>Mehlville</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Nazareth Convent</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2 Nazareth Lane</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Sister Mary</b> Middle <b>Isadore</b> Last <b>Boul</b>			4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1962</b>			
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-27-1890</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher-Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Parochial Schools</b>	11. BIRTHPLACE (City and state or country) <b>Pinckneyville, Ill.</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
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13a. FATHER'S NAME <b>Isadore Boul</b>	13b. MOTHER'S MAIDEN NAME <b>Sedalia Grine</b>	14. NAME OF HUSBAND OR WIFE <b>-----</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>-----</b>	17. INFORMANT <b>Sister Silvers</b> Address <b>2 Nazareth Lane 29</b>
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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) <b>Cardiac Decompensation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yes</b>
DUE TO (b) <b>Atherosclerotic Heart Disease</b>		
DUE TO (c) _____		<b>0 yes</b>

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
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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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
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21. I attended the deceased from 1960 to death and last saw her alive on June 15 62  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>John G. Kellelt MD</b> (Degree or title)	22b. ADDRESS <b>2623 Telegraph</b>	22c. DATE SIGNED <b>7/2/62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-3-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Nazareth Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>2 Nazareth Lane Mehlville 29, Mo</b>
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24. FUNERAL DIRECTOR ADDRESS <b>C. Hoffmeister Mortuaries 7814 S. Broadway</b>	25. DATE RECD. BY LOCAL REG. <b>7-2-62</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy Md.</b>
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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

BY AFFIDAVIT OF

Dr. Kellett

Kingston Burg Ave.

**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 Linus C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.