

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043984
11108
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED **F**iled **NOV 26 1962** Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

VS 300
Rev. 4/59

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2 *219*
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4 *1*
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b 9 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony's Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1361 Maryland Ave.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPHINE C. BOECK						4. DATE OF DEATH Month Day Year November 18 1962					
5. SEX Female		6. COLOR OR RACE Caucasian		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5/22/1879		9. AGE (last birthday) 83		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Germany		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME John Boeck				13b. MOTHER'S MAIDEN NAME Josephine Koppenstetter				14. NAME OF HUSBAND OR WIFE - - - - -			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Address Mrs. J. Medart 59 Clermont Lane			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION ACUTE										INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ATHEROSCLEROTIC HEART DISEASE										UNK	
DUE TO (c) 420.0											
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 checked="" 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 10-24-62 to 11-18-62 and last saw her ^{her} _{him} alive on Nov 17 1962 Death occurred at 12:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <i>Henry Cooper MD</i>						22b. ADDRESS 818 Olive St.			22c. DATE SIGNED 11/19/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov. 20, 1962		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)			
24. FUNERAL DIRECTOR <i>Arthur Donald</i>				ADDRESS 3840 Lindell Blvd.		25. DATE RECD. BY LOCAL REG. NOV 19 1962		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

USE BLACK INK OR TYPEWRITER RIBBON

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Du R Warner

Paul Brown Beldy

Monday 12 to 3

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

Francis Wilkinson

Licensed Embalmer No.

3565

P. O. Address

3840 Lindell

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.