

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-045053

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 153A

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 18 1963

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		Length of stay in 1b 3 yrs	c. CITY OR TOWN St. Charles 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. Charles Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 525 N Fourth Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) Theresa Boschert			4. DATE OF DEATH Month Nov Day 10 Year 1963			
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb 20 '76	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY In Own Home	11. BIRTHPLACE (City and state or country) Portage des Sioux, Mo.		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Peter Jacob		13b. MOTHER'S MAIDEN NAME Catherine Pfeiffer		14. NAME OF HUSBAND OR WIFE Joseph Boschert (deceased)		
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. None		17. INFORMANT Agnes Dwigins, St. Charles, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cecum		INTERVAL BETWEEN ONSET AND DEATH 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause - last. DUE TO (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease		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	
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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 July 1963 to Nov 10, 1963 and last saw her alive on Nov. 2, 1963
Death occurred at 9:30 p on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thomas A. Schneider, MD	22b. ADDRESS 207 N. 5th, St. Charles, Mo.	22c. DATE SIGNED 11-12-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov 13, 1963	23c. NAME OF CEMETERY OR CREMATORY St. Francis Cath Cem
23d. LOCATION (City, town, or county) Portage des Sioux, Mo.		(State)

24. FUNERAL DIRECTOR PRINSTER-BAUE INC	ADDRESS ST CHARLES, MO.	25. DATE RECD. BY LOCAL REG. Nov-13-1963	26. REGISTRAR'S SIGNATURE <i>Mabel Zumwalt Dep</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

VS 300	
Rev. 4/59	
1 <u>0928</u>	
2 <u>0928</u>	
3	
4 <u>1</u>	
5 <u>2</u>	
6	
7 <u>0</u>	
8 <u>2</u>	
9 <u>153.0</u>	
10	
11	
12 <u>06.0</u>	
13 <u>5.0</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF ILLINOIS

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 Frederic M. Bane

Licensed Embalmer No. 4607

P. O. Address St. Charles, 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.