

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND SAFETY

0029520

REGISTERED 05 64 17

Registration District No. 500 Primary Registration District No. 500 Registrar's No. 2389 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 4000  
2 4006  
3 2  
4 0  
5 1  
6  
7 0  
8 2  
9 332x  
10  
11  
12 39-0  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Westwood</b>		Length of stay in 1b	c. CITY OR TOWN <b>University City</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>St. John's Mercy Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>564 Stratford</b>	
3. NAME OF DECEASED (Type or print) -First <b>Harry</b> Middle <b>M</b> Last <b>Boeckmann</b>			4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1964</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>Nov. 11, 1881</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Semi-retired</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>John Boeckmann</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Sophia Alpers</b>	
14. NAME OF HUSBAND OR WIFE <b>Alice W. Boeckmann</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>			
16. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT <b>University City Missouri</b> <b>Mrs. Alice W. Boeckmann 564 Stratford</b>			
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>Arterio Sclerotic Cerebral Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1.5 hr</b>
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)					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 <b>1955</b> to <b>7-18-64</b> and last saw <sup>her</sup> him alive on <b>7-17-64</b> Death occurred at <b>8:30 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Carl J. Boeckmann MD</i> (Degree or title)		22b. ADDRESS <b>1854 Ferguson Highway</b>		22c. DATE SIGNED <b>7-18-64</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>July 20, 1964</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis Cnty, Missouri</b> (State)	
24. FUNERAL DIRECTOR <b>Lupton Chapel Inc. 7233 Delmar Blvd.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>7-20-64</b>	26. REGISTRAR'S SIGNATURE <i>John B. Murphy MD</i>		

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Carl Reis  
7016 Kingsbury

*August 20th*

*Wheeler Co.*

*Boeckmann*

**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 *Clarence H. Murray*

Licensed Embalmer No. *4011*

P. O. Address *H. Reis, 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.