

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

28468

1. PLACE OF DEATH

County.....

Registration District No.....

791

1000

Township.....

Primary Registration District No.....

City *St. Louis*

(No. *4741*)

Midwest

File No.....

Registered No.....

8370

St.....

Ward.....

2. FULL NAME

Mary M. Bohland

(a) Residence. No. *4741*

St. *Midwest*

Ward. *2*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs. *7*

mos.

ds.

How long in U.S., if of foreign birth?

Yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Fred Bohland

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Dec. 10-1865

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

64

8

12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

Household

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Troy, Ill.

10. NAME OF FATHER

John Fickler

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Johanna Metz

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14.

INFORMANT

(Address)

August Bohland

4741 Midwest

15. AUG 22 1930

FILED

May C. Starnes

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Aug 22 1930

17.

I HEREBY CERTIFY, That I attended deceased from *Aug 20*, 19*30* to *Aug 22*, 19*30* that I last saw h. *alive* on *Aug 21*, 19*30*, and that death occurred, on the date stated above, at *12:30 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

108 Lobar Pneumonia

CONTRIBUTORY (SECONDARY)

101A

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH.....

DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *J. E. Penrod*

8/22, 1930 (Address) *2202 S. Benz*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Troy Ill.

DATE OF BURIAL

Aug. 25 1930

20. UNDERTAKER

Michal

ADDRESS

3517 Pitalozzi

WRITE PLAINLY, WITH UNFADING INK--- THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

