S. No. 2
0M—5-43
v. 5-17-39
I X36671

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

4002

State File No.

FILED FEB 24 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1283

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4747 Labadie Ave. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County
(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")
(d) Street No. 4747 Labadie Ave. 000
(If rural, give location) 17
(e) Citizen of foreign country? (Yes or No) 9
If yes, name country 0

3. (a) PRINT FULL NAME William A. Bohnenkamp

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mathilda Bohnenkamp
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased Nov. (Month) 8 (Day) 1869 (Year)

8. AGE: Years	Months	Days	If less than one day
75	2	29	hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country) 9
10. Usual occupation H
11. Industry or business Retired
FATHER
12. Name William Bohnenkamp
13. Birthplace (City, town, or county) Germany 4 (State or foreign country)
MOTHER
14. Maiden name Hannah Bohnenkamp
15. Birthplace (City, town, or county) Germany 4 (State or foreign country)
16. (a) Informant Mathilda Bohnenkamp
(b) Address 4747 Labadie Ave.
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2-10-45 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Crematory
18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.
19. (a) FEB 9 1945 (Date received local registrar) (b) J. F. Bledsek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 7 year 1945 hour 6 minute 30 A M.

21. I hereby certify that I attended the deceased from July 29, 1944 to Feb. 6, 1945 that I last saw him alive on Feb 6, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Gastric and Intestinal Hemorrhage	1 day
Due to Cancer of duodenum, ulcer of duodenum,	7 mo.
Due to Metastasis to liver	
Other conditions Severe Jaundice (Include pregnancy within 3 months of death) Chronic Nephritis	3 mo.

Major findings:
Of operations no operation
Of autopsy no autopsy.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Walter C. G. Kirchner (M. D. or other)
Address 5021 Gravois Ave. Date signed 2/7/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Kirchner
Metropolitan Bldg.
2 to 4

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.....

.....Registered Apprentice No.....,

working under my personal supervision.

Signed Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.