

S. No. 2
 OM-5-43
 v. 5-17-39
 I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **28462**
 Registrar's No. **7493**

FILED SEP 3 1946
 Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County **St. Louis, Mo.**
 (b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4232 Virginia Ave.,
(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 **Missouri** (b) County **000**
 (c) City or town **St. Louis** **1517**
(If outside city or town limits, write "RURAL")
 (d) Street No. **4232 Virginia Ave.,**
(If rural, give location) **9**
 (e) Citizen of foreign country? _____ (Yes or No) **0**
 If yes, name country _____

3. (a) PRINT FULL NAME **Antonette Bonk**
 3. (b) If veteran, name war **None** 3. (c) Social Security No. _____
 4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **About 89 years**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Aug 28** day **28**
 year **1946** hour **8:30 P M** minute _____ M. _____
 21. I hereby certify that I attended the deceased from **Aug 25** 19**46** to **Aug 28** 19**46**
 that I last saw her alive on **Aug 28** 19**46**
 and that death occurred on the date and hour stated above.

8. AGE: Years **Abt 89** Months _____ Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death: **Chronic Myocarditis**
 Due to **Arterio Sclerosis**
 Due to **Senility**
 Other conditions: **95**
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations: _____
 Of autopsy: _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

9. Birthplace **Poland** **4**
(City, town, or county) (State or foreign country)
 10. Usual occupation **None**
 11. Industry or business _____
MOTHER FATHER
 12. Name **Unknown**
 13. Birthplace **Poland** **4**
(City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Poland** **4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Sophia Bonk**
 (b) Address **4232 Virginia Ave.,**
Burial (b) Date thereof **8-31-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Calvary Cemetery**
Southern Funeral Home
 18. (a) Signature of funeral director _____
 (b) Address **6322 S. Grand Blvd.**
 19. (a) **AUG 30 1946** **J. F. Bruneau**
(Date received local registrar) (Registrar's signature)

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? _____
 While at work? _____ (Specify type of place) (c) Means of injury _____
 23. Signature **W. C. Holdreid** (M. D. or other) **W. C.**
 Address **4205 Virginia** Date signed **8/29/46**

1917-1918

*Dr. W. E. Holderness
4205-a Va.*

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 *J. Wm. Binkley*.....

Licensed Embalmer No. *3653*.....

P. O. Address *St. Louis, 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 this body is not embalmed, fact should be so stated above.