

FILED AUG 17 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28753

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 517 PRIMARY REG. DIST. NO. 3066 Registrar's No. 1924

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY St. Louis  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri b. COUNTY 609 |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkwood |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis                                   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION, 349 E. Bodley Ave.                           |  | d. STREET ADDRESS (If rural, give location) 4446 Floriss Ave.  |  |

|   |                |                      |  |
|---|----------------|----------------------|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) William | b. (Middle) L. | c. (Last) Bohnenkamp | 4. DATE OF DEATH (Month) (Day) (Year)<br>August 7 1949 |
|---|----------------|----------------------|--|

|             |                        |  |                                |                                    |                        |                      |                       |                      |
|-------------|------------------------|--|--------------------------------|------------------------------------|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH March 6, 1873 | 9. AGE (In years last birthday) 76 | 10 UNDER 1 YEAR Months | 10 UNDER 1 YEAR Days | 10 UNDER 1 YEAR Hours | 10 UNDER 1 YEAR Min. |
|-------------|------------------------|--|--------------------------------|------------------------------------|------------------------|----------------------|-----------------------|----------------------|

|  |                                       |   |                                     |
|--|---------------------------------------|---|-------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer | 10b. KIND OF BUSINESS OR INDUSTRY law | 11. BIRTHPLACE (State or foreign country) Mascoutah, Ill. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|--|---------------------------------------|---|-------------------------------------|

|                            |                                   |  |
|----------------------------|-----------------------------------|--|
| 13a. FATHER'S NAME unknown | 13b. MOTHER'S MAIDEN NAME unknown | 14. NAME OF HUSBAND OR WIFE Maude Bohnenkamp |
|----------------------------|-----------------------------------|--|

|  |                              |  |                        |
|--|------------------------------|--|------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME Mr. Louis Bohnenkamp | ADDRESS 349 E. Bodley. |
|--|------------------------------|--|------------------------|

|   |   |         |                                  |
|---|---|---------|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION Kirkwood, Mo.   |         | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Frontal Sinus with Cerebral Metastasis  |         | 5 months                         |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |         | 160X                             |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. Pernicious Anemia   |   | 19 yrs. |                                  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

|  |  |                            |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from Oct. 2, 1945, to Aug. 7, 1949, that I last saw the deceased alive on Aug. 4, 1949, and that death occurred at 7:38 P.M., from the causes and on the date stated above.

|  |   |                         |
|--|---|-------------------------|
| 23a. SIGNATURE (Degree or title) <i>Clarence E. Mueller</i> M.D. | 23b. ADDRESS 634 N. Grand, St. Louis, Mo. | 23c. DATE SIGNED 8/8/49 |
|--|---|-------------------------|

|  |                    |   |  |
|--|--------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 8-10-49. | 24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis, Missouri. |
|--|--------------------|---|--|

|                                  |  |   |                           |
|----------------------------------|--|---|---------------------------|
| DATE REC'D BY LOCAL REG. 8-10-49 | REGISTRAR'S SIGNATURE <i>Herbert R. Lamb, M.D.</i> | 25. FUNERAL DIRECTOR'S SIGNATURE Math Hermann & Son, Inc. | ADDRESS 2161 E. Fair Ave. |
|----------------------------------|--|---|---------------------------|

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

96  
2/3

**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 .....  
Student Embalmer -

Signed \_\_\_\_\_

*Homer H. Fritz*

Licensed Embalmer No. *3882*

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.