

FILED MAY 1 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14367
3707
Registrar's No.

318

1003

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Brothers Hospital				d. STREET ADDRESS (If rural, give location) 8202 Minnesota Avenue			
3. NAME OF DECEASED (Type or Print) WILLIAM		a. (First)		b. (Middle) J.		c. (Last) BOHL	
4. DATE OF DEATH (Month) (Day) (Year) Apr. 21, 1950		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH July 17, 1911		9. AGE (In years last birthday) 38		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME William A. Bohl		13b. MOTHER'S MAIDEN NAME Lizzie Hoffman		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. N.W.2 492-05-1998		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lizzie Bohl 8202 Minnesota Avenue			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Endocarditis INTERVAL BETWEEN ONSET AND DEATH 1 year ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
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) H 21 4			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 April 19, 1950 , to April 21, 1950 , that I last saw the deceased alive on April 20, 1950 , and that death occurred at 7:10 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Dr. J. M. Lawrence M.D.				23b. ADDRESS 2619 7th		23c. DATE SIGNED 4/21/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE April 24, 1950		24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		24d. LOCATION (City, town, or county) (State) Lemay Ferry Road	
DATE REC'D BY LOCAL REG. APR 24 1950		REGISTRAR'S SIGNATURE J. B. Pasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister U. & L. Co. 3814 S. Broadway			

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

[Handwritten signature]

50-0107

7619 Broadway Ave.

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 *Linus C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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.