

FILED DEC 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38733

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1003

State File No. 10913

10913

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, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) TOWN St. Louis 2139	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 5800 Arsenal Street. 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1			

3. NAME OF DECEASED (Type or Print)	a. (First) LOUIS	b. (Middle)	c. (Last) BOLTE	4. DATE OF DEATH (Month) (Day) (Year) DEC. 7, 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Oct 12 1898	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY Nil	11. BIRTHPLACE (State or foreign country) Fort Madison, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Joseph Bolte	13b. MOTHER'S MAIDEN NAME Elizabeth Bentler	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clara Robinson, Ft. Madison, Iowa
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis, localized		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Rupture of Gall bladder DUE TO (c) Carcinoma of Ampulla of Vater		
	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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 153X
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22. I hereby certify that I attended the deceased from 11-5-51, 19__, to 12-7-51, 19__, that I last saw the deceased alive on 12-7-51, 19__, and that death occurred at 3:45P m., from the causes and on the date stated above.

23a. SIGNATURE J. Donald Ferryman (Degree or title)	23b. ADDRESS 1515 Lafayette Avenue,	23c. DATE SIGNED 12-8-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-7-51	24c. NAME OF CEMETERY OR CREMATORY City	24d. LOCATION (City, town, or county) (State) Ft. Madison, Iowa
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DATE RECD BY LOCAL HEALTH DEPT. DEC 10 1951	REGISTRAR'S SIGNATURE J. Earl Smith M.D. W.M.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe-4700 Washington Blvd
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Edmond R. Umelich

Licensed Embalmer No. 4283

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.