

FILED AUG 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24276
Registrar's No. 6754

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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) OR TOWN ST. LOUISIS Mo		c. CITY OR TOWN ST. LOUISIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION. 1008 HICKORY		e. STREET ADDRESS (If rural, give location) 22 1008 HICKORY 2229	

3. NAME OF DECEASED (Type or Print)	a. (First) ANTHONY	b. (Middle) BODONY	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) JULY 19 1954
-------------------------------------	--------------------	--------------------	-----------	---

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED WIDOWED	8. DATE OF BIRTH MAR. 1 1889	9. AGE (In years last birthday) 65	10. UNDER 1 YEAR Months	11. UNDER 1 YEAR Days	12. UNDER 1 YEAR Hours	13. UNDER 1 YEAR Min.
-------------	------------------------	--	------------------------------	------------------------------------	-------------------------	-----------------------	------------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DAY LABORER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) SYRIA	12. CITIZEN OF WHAT COUNTRY?
--	-----------------------------------	---	------------------------------

13a. FATHER'S NAME MICHAEL BODONY	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE UNKNOWN
--------------------------------------	--------------------------------------	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ROSE SARKIS	ADDRESS 1008 HICKORY
--	---------------------------------	--	-------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		1 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis DUE TO (c)		5 yrs
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 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) 331X
--	--	---

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 Jan 27, 1948, to July 19, 1954, that I last saw the deceased alive on July 19, 1954, and that death occurred at 10:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE J. Schindewolf M.D.	(Degree or title)	23b. ADDRESS 2026 S. 9th ST	23c. DATE SIGNED 7-20-54
---------------------------------------	-------------------	--------------------------------	-----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 22 1954	24c. NAME OF CEMETERY OR CREMATORY S.S. PETER Y PAUL	24d. LOCATION (City, town, or county) (State) ST. LOUIS, Mo
---	---------------------------	---	--

DATE REC'D BY LOCAL REG. JUL 21 1954	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis	ADDRESS 2906 Gravois
---	--	--	-------------------------

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed

Leo J. Budde

Licensed Embalmer No. *398*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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