

FILED JAN 17 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2658
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 335

300
-57

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, give TOWNSHIP only) OR TOWN ST LOUIS MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6516 PENNSYLVANIA AVE.		Length of stay in lb 1 YEAR	STREET ADDRESS 6516 PENNSYLVANIA AVE.		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CHARLES BOHN			4. DATE OF DEATH Month Day Year JAN 9 58		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 23 1885		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 72 Months 0 Day 18 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY COAL MINER		11. BIRTHPLACE (City and state or country) TRENTON ILL.	
10c. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME JACOB BOHN		13b. MOTHER'S MAIDEN NAME CATHERINE STREIF	
14. NAME OF HUSBAND OR WIFE EMMA BRAUER BOHN		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. 339-10-3339	
17. INFORMANT JACOB H FRENCH		Address 6516 PENNSYLVANIA AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Asterialeptic Ht. Pleural</u> DUE TO (c) <u>420.0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Encephalomalacia - Cerebral Schvosis, some Pleuritic Wlors</u>					INTERVAL BETWEEN ONSET AND DEATH <u>approx 4-5 day</u>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>3/16/56</u> to <u>1-9-58</u> and last saw ^{her} <u>him</u> live on <u>1-9-58</u> Death occurred at <u>10:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Joseph V. O'Donnell M.D.</u>			22b. ADDRESS <u>634 North Grand.</u>		22c. DATE SIGNED <u>1-11-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE <u>1-10-58</u>	23c. NAME OF CEMETERY OR CREMATORY ST DOMINICK CEM.		23d. LOCATION (City, town, or county) (State) BREEZE ILL.
24. FUNERAL DIRECTOR ALBERT H HOPPE 1700 WASHINGTON BL.			25. DATE RECD. BY LOCAL REG. JAN 11 '58		26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> S.P.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *John L. Pennington*

Licensed Embalmer No. *4194*

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.