

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019506

STATE FILE NUMBER

5856

FILED JUN 13 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5856

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LUTHERAN</b>		Length of stay in lb <b>2-23</b>	d. STREET ADDRESS (If outside, give location) <b>2857 VICTOR ST</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>BOHN</b> Last <b>BOHN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>3</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 10 1913</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>DENTAL SUPPLY</b>	9. AGE (In years last birthday) <b>44</b>
10a. BIRTHPLACE (City and state or country) <b>MISSOURI</b>		11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>		13. FATHER'S NAME <b>CHARLES BOHN</b>	
14. MOTHER'S MAIDEN NAME <b>MARY URBAN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>489-07-5039</b>		17. INFORMANT <b>DOROTHY BOHN</b> Address <b>2857 VICTOR ST</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, with influenza</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7-1/3</b>
DUE TO (b) <b>Ch. nephritis (arteriosclerotic) diabetes mellitus</b>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>260X</b>		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 <b>7:30 P.</b> Month <b>5</b> Day <b>58</b> Year <b>58</b>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>ST. LOUIS</b>	
20e. CITY, TOWN, OR LOCATION <b>ST. LOUIS</b>		20f. COUNTY <b>ST. LOUIS</b>	
20g. STATE <b>MO</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	

21. I attended the deceased from <b>5/1 58</b> to <b>6/3 58</b> and last saw her alive on <b>6/3 58</b> Death occurred at <b>7:30 P. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>Ralph Berglund</b> (Degree or title)	22b. ADDRESS <b>3203 S Grand</b>
22c. DATE SIGNED <b>6/5/58</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>JUNE 6 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>
24. FUNERAL DIRECTOR <b>Thomas Kutze</b> ADDRESS <b>2906 Travis</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 6 58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>

300 1-56  
All symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

15-1801

**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 *Lowell C. Hill*.....

Licensed Embalmer No. *434*.....

P. O. Address *2906*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.