

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006910

STATE FILE NUMBER

2 1597

FILED MAR 2 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300
-57

294
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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>St. Louis</u> | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5064 Thrush Ave.</u> | Length of stay in 1b | d. STREET ADDRESS <u>5064 Thrush Ave</u> (If outside, give location) | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK BODNAR</u> | 4. DATE OF DEATH Month Day Year <u>Feb. 14, 1959</u> |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar. 31, 1875</u> | 9. AGE (In years) <u>83</u> (birthday) | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Park Dept.</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Hungary</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Joseph Bodnar</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Veronica</u> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or not unknown) (If yes, give dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT <u>Mary Brandtner</u> Address <u>5064 Thrush</u> |
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| 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>Cardiac Deкомпensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerotic Heart Disease</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>Pneumonia</u> | INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2</u> <u>years</u> |
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| 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.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. | 20d. INJURY OCCURRED WHILE AT WORK <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 |
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| 21. I attended the deceased from <u>Feb 5, 1959</u> to <u>present</u> and last saw <u>alive</u> on <u>Feb 5, 1959</u> Death occurred at <u>Feb 14, 1959 7:30a.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <u>Charles A. Madden, M.D.</u> | 22b. ADDRESS <u>3121 N. Grand</u> | 22c. DATE SIGNED <u>2-14-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Feb 16 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>DHN STYGAR & SON - 5541 RIVERVIEW BLVD.</u> | 25. DATE RECD. BY LOCAL REG. <u>FEB 15 '59</u> | 26. REGISTRAR'S SIGNATURE <u>Loan Smith, D.D.</u> |
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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 *[Handwritten Signature]*

Licensed Embalmer No. *3980*

P. O. Address *[Handwritten Address]*

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.