

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 25 1960

-60-007954

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 1144** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 8 days		c. CITY OR TOWN Beverley Hills		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3506 Lucas Hunt Rd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last BOHL				4. DATE OF DEATH Month Jan. Day 31 Year 1960					
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 9/4/1878	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer Manager			10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME JULIUS BOHL			13b. MOTHER'S MAIDEN NAME LOUISE KAVALEWSKI			14. NAME OF HUSBAND OR WIFE ANNA ST. CYR			
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. 494-01-8856		17. INFORMANT Anna Bohl			Address 3506 Lucas Hunt Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 5 yrs.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis.							10 yrs		
DUE TO (c) 420.0									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____ a.m. _____ p.m.	Month, Day, Year								
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	
21. I attended the deceased from 8-4-64 to 1-31-60 and last saw him alive on 1-30-60				Death occurred at 4:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) J. O. Schepel, M.D.				22b. ADDRESS 634 No. Grand, St. Louis, Mo			22c. DATE SIGNED 2-1-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Feb. 3, 1960	23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		23d. LOCATION (City, town, or county) St. Louis County		23e. STATE Mo.			
24. FUNERAL DIRECTOR Callan Kelly		ADDRESS 7267 Natural Bridge		25. DATE RECD. BY LOCAL REG. FEB 1 1960		26. REGISTRAR'S SIGNATURE Robert Smith, M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S.P.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James A. Lamm

Licensed Embalmer No. 4142

P. O. Address St. Louis

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