

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-020696

FILED VS JUN 15 1960

Registration District No. **318**

Registration District No. **1003**

Registrar's No. **5868**

STATE FILE NUMBER

INDEXED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 40 Yrs.		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 858 Hamilton			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 2734a Wyandotte		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle E. Last BOHAJEK				4. DATE OF DEATH Month June Day 6 Year 1960			
5. SEX Female	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 7/3/1900	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Unk. Kentucky		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Oliver			13b. MOTHER'S MAIDEN NAME Ada Fogle		14. NAME OF HUSBAND OR WIFE Edward Bohajek		
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. Unk.	17. INFORMANT Address Edward Bohajek, 2734a Wyandotte			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO (b) _____ 1631 DUE TO (c) _____ not cell carcinoma of lung						INTERVAL BETWEEN ONSET AND DEATH 6 months	
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 checked="" 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 2/15/60 to 6/6/60 and last saw her ^{her} him alive on 6/6/60 Death occurred at 4 AM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE James C. Wood M.D. (Degree or title)				22b. ADDRESS 35 North Central		22c. DATE SIGNED 6/7/60 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/9/60	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill		23d. LOCATION (City, town, or county) St. Louis Co., Mo.			
24. FUNERAL DIRECTOR ADDRESS McLaughlin, 2301 Lafayette(4)				25. DATE RECD. BY LOCAL REG. JUN 7 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

Dr. J. Woods
35 N CENTRAL — 1 P.M.
PA6-0683

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

H. G. Farris

Licensed Embalmer No. *338*

P. O. Address *H. G. Farris*

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.