

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-022498

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1440 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 5 1963

VS 300
 Rev. 4/59
 1 4000
 2 9269
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 4 1
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 7 0
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY: <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: <u>Mo</u> b. COUNTY: <u>---</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: <u>KOCH</u>		Length of stay in 1b: <u>7 days</u>	c. CITY OR TOWN: <u>ST LOUIS</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: <u>ROBT KOCH HOSP.</u>		Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location): <u>1317^a MONROE</u>
3. NAME OF DECEASED (Type or, print) First: <u>KATE</u> Middle: <u>BOSANKO</u> Last: <u>BOSANKO</u>		4. DATE OF DEATH Month: <u>APR.</u> Day: <u>29</u> Year: <u>1963</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</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>3-10-93</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>	11. BIRTHPLACE (City and state or country): <u>MISSOURI</u>
13a. FATHER'S NAME: <u>FRANK LODENKAMPER</u>		13b. MOTHER'S MAIDEN NAME: <u>MINNIE KRAUSE (?)</u>	
14. NAME OF HUSBAND OR WIFE: <u>G. BOSANKO</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of): <u>023x</u>	
16. SOCIAL SECURITY NO.:		17. INFORMANT Address: <u>HOSPITAL RECORD - KOCH HOSP.</u>	
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>Acute pulmonary infarction</u> DUE TO (b) <u>embolism (from rt. femoral vein)</u> DUE TO (c) <u>Syphilitic heart disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a): <u>023x</u>			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 checked="" type="checkbox"/> NO <input 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 <u>April 20/63</u> to <u>April 29/63</u> and last saw her alive on <u>April 29/63</u> . Death occurred at <u>4:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title): <u>Frank Cohen MD</u>		22b. ADDRESS: <u>Robt Koch Hosp Koch</u>	
22c. DATE SIGNED: <u>4/30/63</u>		22d. LOCATION (City, town, or county) STATE: <u>ST. LOUIS. MO</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify): <u>REMOVAL</u>	23b. DATE: <u>5-8-63</u>	23c. NAME OF CEMETERY OR CREMATORY: <u>CALVARY CEM.</u>	
24. FUNERAL DIRECTOR ADDRESS: <u>EARL HILLEMANN, OVERLAND, MO.</u>		25. DATE RECD. BY LOCAL REG.: <u>5-2-63</u>	26. REGISTRAR'S SIGNATURE: <u>John B. Mumfley M.D.</u>

APR 1974

with the body...
(this is a copy of the original body)

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

Carl J. Alleman

Licensed Embalmer No.

3501

P. O. Address

Greeland 14 MO

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.