

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

10455

1. PLACE OF DEATH

County St. Louis
Township Central
City St. Louis

Registration District No. 789
Primary Registration District No. 6603B

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Edward H. Bochniker

(a) Residence No. 5083 Washington St., _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clarison J. Bochniker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 4, 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
66 11 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Manager of
(b) General nature of industry, business, or establishment in which employed (or employer) Carroll Mfg Co
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Warsaw, Poland
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER August Bochniker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Fredrika Nery

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Poland
(STATE OR COUNTRY)

14. INFORMANT Susan M. Bochniker
(Address) 5283 Washington av.

15. FILED 3/29 1923
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 27 1923

17. I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to March 27, 1923, that I last saw him alive on March 27, 1923, and that death occurred, on the date stated above, at 3:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Valvular Insufficiency
92A
97 90
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Arterial Sclerosis
Scurvy
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF 3/4

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) J. W. Drivier, M. D.
, 19 (Address) 331 Frisco Alley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Philadelphia Pa DATE OF BURIAL 3-30 1923

20. UNDERTAKER Magover ADDRESS 3671 Olive St.

Shipped to Philadelphia Pa Mch 30th - 1923

X. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill*; (a) *Salesman, (b) Grocery*; (a) *Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH

County St. Louis 789 State MISSOURI. Registered No. 789
 Township Central 6603-12 of Village _____ or _____
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Edward H. Boehnen
 (a) Residence. No. 5283 Washington St., _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <small>(write the word)</small> <u>Married</u>
5a If married, widowed, or divorced: HUSBAND of _____ (or) WIFE of _____		
6 DATE OF BIRTH (month, day, and year) _____		
7 AGE	Years _____	Months _____ Days _____
<small>IF LESS than 1 day, _____ hrs. or _____ min.</small>		

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9 BIRTHPLACE (city or town) _____
(State or country) _____

10 NAME OF FATHER	_____
11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____	_____
12 MAIDEN NAME OF MOTHER	_____
13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____	_____

14 Informant _____
(Address) _____

15 Filed 3-29-23 He C A Pre
11-8184 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 27 1923
17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows:

CONTRIBUTORY _____
(SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted _____
 If not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) _____, M. D.
 _____, 19____ (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL _____ **DATE OF BURIAL** _____

20 UNDERTAKER _____ **ADDRESS** _____

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SUPPLEMENTAL

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

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BY PHYSICIAN.