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

Do not use this space.

19421

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 5002

City St. Louis, Mo. (No. Mo. Baptist Hospital St. ..... Ward)

2. FULL NAME Whilmina Marie Bohlman

(a) Residence. No. 6431 Mortel Ave. St. 12 Ward. St. Louis Co.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John H. Bohlmann

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 26, 1858.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	70	5	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Atlantic
(STATE OR COUNTRY) Ocean (9)

PARENTS

10. NAME OF FATHER Henry Sievert

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

12. MAIDEN NAME OF MOTHER Whilmina Wallenbrock

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

14. INFORMANT Emma Dallahuide
(Address) 6431 Myrtle Ave

15. FILED MAY -2 1929, 19..... Max C. Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1st. 1929

17. I HEREBY CERTIFY, That I attended deceased from April 21, 1929, to May 1st, 1929 that I last saw her alive on May 1st, 1929, and that death occurred, on the date stated above, at 10.45 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myo Carditis (Acute)
73 A
1521
(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Collulitus of Neck - Cause unknown
(duration) ..... yrs. ..... mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Chester G. Poe, M.D

19 (Address) 6125 Easton E

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Concordia, Mo

DATE OF BURIAL May 5, 1929

20. UNDERTAKER H. F. Duensing

ADDRESS Concordia, Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. 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.

32 562-4 Omn.

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