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

Do not use this space.

791
1003

11577

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. ..... Registered No. 2783

City St Louis (No. 4631 Steffens St. ..... Ward)

2. FULL NAME Katherine Bomanz

(a) Residence. No. 4631 Steffens St., 15 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 13 - 1910

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
20	4	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer) 255
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo

PARENTS

10. NAME OF FATHER Henry Bomanz
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Hungary
12. MAIDEN NAME OF MOTHER Barbara Kratochwill
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Hungary

14. INFORMANT Henry Bomanz
(Address) 4631 Steffens

15. FILED ..... 19.. Max C Parker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 2 1931

17. I HEREBY CERTIFY, That I attended deceased from 2-24, 1931, to 3-2, 1931, that I last saw her alive on 3-2, 1931, and that death occurred, on the date stated above, at 1.50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Colitis
1208
1230
120
(duration) yrs. 6 mos. X ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF (1)
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) G W Carson, M. D
2/3, 1931 (Address) 5100 Delmar

*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	DATE OF BURIAL
St Pauls Churchyard	3-3- 1931
20. UNDERTAKER	ADDRESS
Hacker Helderle	2331 S Broadway

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.