

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 26800

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Louis
 (b) City or town KIRKWOOD
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Rosecrest Convalescent Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution ? (Specify whether
 years, months or days)
 In this community ? (Specify whether
 years, months or days)

3. (a) PRINT 403
FULL NAME Lena Bohlander3. (b) If veteran, name war -- 3. (c) Social Security No. --

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife George 6. (c) Age of husband or wife if
 alive 8 21 1857 years
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>11</u>	<u>9</u>	hr. min.

9. Birthplace Germany
(City, town, or county) (State or foreign country)10. Usual occupation none11. Industry or business --

12. Name Theophel Schur
 18. Birthplace Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name unknown
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mr. O. Za pps
 (b) Address 5511 Garrison
 17. (a) Burial (b) Date thereof Aug 1/39
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director Fendler Und. Co.
 (b) Address 7420 Michigan

19. (a) 7/31 (b) G. R. Meyer & D.
 (Date recorded local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mol (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL.")
 (d) Street No. 4362 Washington
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? -- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
 year 1939 hour 7:1 minute 15 A. M.

21. I hereby certify that I attended the deceased from July 29
 _____, 1939 to July 30, 1939
 that I last saw her alive on July 29, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis, general
 Due to unknown
 Due to 47

Other conditions hypertension
 (Include pregnancy within months of death)
 Major findings: hypertension
 Of operations None

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) NO
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

Signature L. S. Sattler (M. D. or other) MD
 Address 607 N Grand Date signed 10-2-39

STATE BOARD OF HEALTH
DIVISION OF HEALTH
BUREAU OF HEALTH
STATE OF CALIFORNIA

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

26800 ✓
Do not use this space.

1. PLACE OF DEATH
(a) County St. Louis Registration District No. _____
(b) Township W. Ashwood Primary Registration District No. _____
(c) City W. Ashwood (d) Street No. Rosecrest Conventual Home Registered No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lena Bohlander
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
81 11 9
OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as saw mill, bank, etc. unknown
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
FATHER
13. NAME Theophil Schuster
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
MOTHER
15. MAIDEN NAME Wendy
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
17. INFORMANT (ADDRESS) Mr. A. G. Gappa 52-11 1st St. St. Louis
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Matthews 8-1-39
19. FUNERAL DIRECTOR (ADDRESS) F. Smiles 7430 Michigan
20. FILED 7-31-1939 T. R. Meyer M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-30-1939
22. I HEREBY CERTIFY, That I attended deceased from 7-29-39 to 7-30-39
I last saw h. in alive July 27, 1939 Death is said to have occurred on the date stated above, at 11 P.M.
The principal cause of death and related causes of importance were as follows:
Arterio Sclerosis Coronary Date of onset _____
unknown
Other contributory cause of importance:
Hypertension
none
none
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) C. O. Settles M. D.
(Address) 607 N. Grand

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-26800

1939