

No. 2  
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X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** APR 5 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. **10191**  
Registrar's No. **12**

Registration District No. **234** Primary Registration District No. **5815**

**1. PLACE OF DEATH:**  
(a) County **MORGAN**  
(b) City or town **RUPA LA LAWCREEK TWP**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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 **WIFE**

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **MISSOURI** (b) County **MORGAN**  
(c) City or town **RUPA LA**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **WEST OF VERSAILLES**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **MARY BOHNING**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **MARCH** day **25th** year **1946** hour **4** minute \_\_\_\_\_  
**21. I hereby certify that I attended the deceased from** **DEC. 1st** 19 **46** to **MARCH 24** 19 **46**  
that I last saw him **EA** alive on **MARCH 24** 19 **46** and that death occurred on the date and hour stated above

7. Birth date of deceased **APRIL 14 1860**  
(Month) (Day) (Year)  
**8. AGE:** Years **85** Months **11** Days **11** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace **STOVER MO**  
(City, town, or county) (State or foreign country)

Immediate cause of death **CARDIAC FAILURE** Duration \_\_\_\_\_  
Due to **HEPATITIS** **6 YR**  
Due to **SENILITY**  
Other conditions **POLYPUUS UTERUS**  
(Include pregnancy within 3 months of death)

**11. Industry or business** \_\_\_\_\_  
**12. Name** **JOHN BOHNING**  
**13. Birthplace** **GERMANY**  
(City, town, or county) (State or foreign country)  
**14. Maiden name** **ANNA UNKNOWN**  
**15. Birthplace** **GERMANY**  
(City, town, or county) (State or foreign country)  
**16. (a) Informant** **JAY BERKSTRESSER**  
(b) Address **VERSAILLES MO**  
**17. (a) BURIAL** (b) Date thereof **3-27-1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **VERSAILLES CEM.**  
**18. (a) Signature of funeral director** **J. H. Steverson**  
(b) Address **Stover Mo.**  
**19. (a) 4/3-1946** (b) **Wm. L. Rippeger**  
(Date received local registrar) (Registrar's signature)

**Major findings:**  
Of operations **NO**  
Of autopsy **NO** **56lb**  
**22. If death was due to external causes, fill in the following:**  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(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 **2 DO.**  
**23. Signature** **A. F. Burkstresser** (M. D. or other) **DO.**  
Address **EL DOTO MO** Date signed **3/27/46**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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 J. L. Stevenson

Licensed Embalmer No. 4073

P. O. Address Stover 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 this body is not embalmed, fact should be so stated above.**

Date Filed 3-46-287  
1-4-46

Registration District No. 234

Primary Registration District No. 5815

Registrar's No. 12

1. PLACE OF DEATH:  
(a) County Morgan  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days)

3. (a) PRINT FULL NAME Mary Bohling  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, divorced, married S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 14 (Month) (Day) (Year)

8. AGE: Years 85 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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SUPPLEMENTARY

10191