

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33748

State File No. \_\_\_\_\_

No. 300  
10-48

FILED OCT 2 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590 Registrar's No. 2459

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

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>PINE LAWN</u>		c. LENGTH OF STAY (In this place) <u>20 YRS</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>PINE LAWN 4151</u>		d. STREET ADDRESS (If rural, give location) <u>4131 JENNINGS RD</u>
3. NAME OF DECEASED (Type or Print) a. (First) <u>LEO</u> b. (Middle) <u>C.</u> c. (Last) <u>BOUNK</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT-22-1952</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT-5-1900</u>	9. AGE (In years last birthday) <u>51</u> IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u>	IF UNDER 1 HR. Hours <u>0</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS - MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>JOHN BOUNK</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA LOZA</u>		14. NAME OF HUSBAND OR WIFE <u>GERTRUDE BOUNK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>498-10-3526</u>	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>MRS. GERTRUDE BOUNK, 4131 JENNINGS RD, ST. LOUIS, MO</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of colon</u> ANTECEDENT CAUSES (b) <u>Ulcer</u> DUE TO (b) <u>Ulcer</u> DUE TO (c) <u>153X</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>1 wk</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>Aug 21</u> , 19 <u>51</u> , to <u>9/22</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>9/22</u> , 19 <u>52</u> , and that death occurred at _____ m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Her Noller MD</u> (Degree or title)			23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>9/23/52</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>SEPT 24-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS - MO</u>	
DATE REC'D BY LOCAL REG. <u>9-23-52</u>		REGISTRAR'S SIGNATURE <u>Nerbert R. Donke MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>L. B. TANNER, Natural Bridge</u>	

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed *John S. Denehy*

Licensed Embalmer No. 4194

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, fact should be so stated above.