S. No. 300
v. 10.48

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

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 15485

FILED APR 23 1953

BIRTH NO. _____ REG. DIST. NO. 3'14 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3703

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS, MISSOURI
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BARNES HOSPITAL Barnes Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2149
d. STREET ADDRESS (If rural, give location): 5507 Lansdowne Ave.

**3. NAME OF DECEASED** (Type or Print)
a. (First): LEONARD
b. (Middle): LOUIS
c. (Last): BOCHANTIN

**4. DATE OF DEATH** (Month): 4 (Day): 7 (Year): 53

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Married
**8. DATE OF BIRTH**: Jan. 16 1925
**9. AGE** (In years last birthday): 28 — If under 1 year: Months, Days — If under 24 hrs: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Clerk
**10b. KIND OF BUSINESS OR INDUSTRY**: Steel Co.
**11. BIRTHPLACE** (City and State or Foreign Country): St. Louis Mo.
**12. CITIZEN OF WHAT COUNTRY?**

**13a. FATHER'S NAME**: Louis Bochantin
**13b. MOTHER'S MAIDEN NAME**: Mary Paschovilet
**14. NAME OF HUSBAND OR WIFE**: June Bochantin

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no or unknown): Yes (If yes give war or period of service): W.W # 2
**16. SOCIAL SECURITY NO.**
**17. INFORMANT'S SIGNATURE OR NAME, ADDRESS**: June Grace Bochantin 5507 Lansdowne

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) CHRONIC GLOMERULONEPHRITIS — 3 years
DUE TO (c) CHRONIC PYELONEPHRITIS — 3 years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

**19a. DATE OF OPERATION**
**19b. MAJOR FINDINGS OF OPERATION**
**20. AUTOPSY?** YES [X] NO [ ]

**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)**
**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.
**21e. INJURY OCCURRED** WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
**21f. HOW DID INJURY OCCUR?** 592X

**22.** *I hereby certify that I attended the deceased from* 3-30, 1953, *to* 4-7, 1953, *that I last saw the deceased alive on* 4-7, 1953, *and that death occurred at* 8:55 a.m., *from the causes and on the date stated above.*

**23a. SIGNATURE**: H Madeira (Degree or title): M.D.
**23b. ADDRESS**: BARNES HOSPITAL
**23c. DATE SIGNED**: 4-7-53

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: 4/10/53
**24c. NAME OF CEMETERY OR CREMATORY**: Memorial Park Cem.
**24d. LOCATION** (City, town, or county) (State): St/Louis County

**DATE REC'D BY LOCAL REGISTRAR**: APR 8 1953
**REGISTRAR'S SIGNATURE**: J Carl Schmid M.D. MPH
**25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS**: Sullivan's 2849 N. Euclid Ave.
(Licensed Embalmer's Statement on Reverse Side)

## 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 Robert L. Franklin

Licensed Embalmer No. 3553

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.