

FILED JUN 24 1954

STANDARD CERTIFICATE OF DEATH

State File No. 20219
Registrar's No. 5448

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 1335 Garrison	

3. NAME OF DECEASED (Type or Print) Helen	a. (First)	b. (Middle)	c. (Last) Bohlen	4. DATE OF DEATH (Month) (Day) (Year) June 14, 1954
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5. SEX F	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED? WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3-2-1892	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Miss.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Unk	13b. MOTHER'S MAIDEN NAME Georgia	14. NAME OF HUSBAND OR WIFE Joe Bohlen
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT'S SIGNATURE OR NAME James Bohlen	ADDRESS 1335 Garrison
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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		INTERVAL BETWEEN ONSET AND DEATH Undt
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Essential Hypertension, Cerebral Thrombosis		
ANTECEDENT CAUSES	Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b)		
	DUE TO (c)		
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 332X
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22. I hereby certify that I attended the deceased from June 8, 19 54, to June 14, 19 54, that I last saw the deceased alive on June 14, 19 54, and that death occurred at 1:10 A.M., from the causes and on the date stated above.

23a. SIGNATURE E. B. Williams	(Degree or title) M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 6/14/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-18-54	24c. NAME OF CEMETERY OR CREMATORY Antioch	24d. LOCATION (City, town, or county) (State) Cold Water Miss.
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DATE REC'D BY LOCAL REG. JUN 17 1954	REGISTRAR'S SIGNATURE Carl Smith MO	25. FUNERAL DIRECTOR'S SIGNATURE T. McClendon	ADDRESS 4535 Washington
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed..... *John K Cunningham*

Licensed Embalmer No. *4476*

P. O. Address *4700 Ham*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.