

FILED DEC 6 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36547**
Registrar's No. **1237**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 65 Yrs	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 2002 Main St.		e. STREET ADDRESS (If rural, give location) 2002 Main St.	

3. NAME OF DECEASED (Type or Print)	a. (First) Frank	b. (Middle)	c. (Last) Bokay	4. DATE OF DEATH (Month) (Day) (Year) Nov. 26, 1954
-------------------------------------	-------------------------	-------------	------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 6, 1876	9. AGE (In years last birthday) 78	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 2 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	--------------------------------------	---	--	---

10a. USUAL OCCUPATION (Give kind of work during past year, if engaged) Ret. (S) Owner Grocery Retail	10b. KIND OF BUSINESS OR INDUSTRY Grocery Retail	11. BIRTHPLACE (City and State or Foreign Country) Everest, Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	--

13a. FATHER'S NAME Joseph Bokay	13b. MOTHER'S MAIDEN NAME Teresa Shamrad	14. NAME OF HUSBAND OR WIFE Elizabeth Bokay
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 487-14-7575	17. INFORMANT'S SIGNATURE OR NAME Mrs Frank Bokay ADDRESS 2002 Main City
--	--	--

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 ? 3 da ? ?
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio Vascular Renal Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) terminal uremia DUE TO (c) Arteriosclerosis General Hypertrophic Arthritis general		
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 7230	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)
--	--	---

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?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **9-18** **1954** to **11-26**, **1954**, that I last saw the deceased alive on **11-26**, **1954** and that death occurred at **11:00p**, from the causes and on the date stated above.

23a. SIGNATURE Wm B. Root M.D. (Degree or title)	23b. ADDRESS 316 No 10th City	23c. DATE SIGNED 11-27-54
---	--------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-29-54	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
---	---------------------------	---	--

DATE REC'D BY LOCAL REG. Nov 29, 1954	REGISTRAR'S SIGNATURE Kathleen M. Allison 4838	25. FUNERAL DIRECTOR'S SIGNATURE Herman W. Sidenfader ADDRESS St. Joseph Mo.
--	--	--

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.....
Robert A. Geph

Licensed Embalmer No. 3308

P. O. Address St. Joseph,

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.