

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 29 1955

State File No. **30611**
Registrar's No. **7852**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____	
b. CITY OR TOWN ST. LOUIS	c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 14 6065 Potomac	

3. NAME OF DECEASED (Type or Print) THEODORE	a. (First) _____	b. (Middle) _____	c. (Last) BONK	4. DATE OF DEATH (Month) (Day) (Year) Sept. 5, 1955
---	------------------	-------------------	-----------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 22, 1873	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Days 8	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Own Shop		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph Bonk	13b. MOTHER'S MAIDEN NAME Rose Armbruster	14. NAME OF HUSBAND OR WIFE Mary Bonk (Deceased)
---------------------------------------	--	---

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. None	17. INFORMANT'S SIGNATURE OR NAME Beulah Deutschman	ADDRESS 6055 Potomac
--	-------------------------------------	--	-----------------------------

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) Pneumonia - R. + L. lung		INTERVAL BETWEEN ONSET AND DEATH 5 days
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Debility + anemia		?
		DUE TO (c) Carcinoma of the rectum		?
		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"/>
------------------------------	--	--

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) 154th
--	--	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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 **8-29-55**, 19____, to **9-5-55**, 19____, that I last saw the deceased alive on **9-5-55**, 19____, and that death occurred at **10:30A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James W. Kerley MD	23b. ADDRESS 1515 Lafayette	23c. DATE SIGNED 9-5-55
--	------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Sept. 8, 1955	24c. NAME OF CEMETERY OR CREMATORY St. Pauls Church Yard	24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.
--	--------------------------------	---	---

DATE REC'D BY LOCAL REG. SEP 7 1955	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Wm. Schumacher	ADDRESS 3013 Meramec St.
--	--	--	---------------------------------

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

11-7-11

STATE OF ILLINOIS

DEPARTMENT OF HEALTH

STATE BOARD OF HEALTH

CHICAGO, ILLINOIS

STATE OF ILLINOIS

DEPARTMENT OF HEALTH

STATE BOARD OF HEALTH

I

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.....
Joe Haupt

Licensed Embalmer No. 47

P. O. Address St. Louis

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.