FILED JAN 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42726
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11508

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION EN ROUTE CITY Hosp. — Length of stay in 1b 23 d

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 2600 GRAVOIS AVE (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First AUGUST Middle Last BOLHOFNER

4. DATE OF DEATH Month DEC. Day 13 Year 1956

5. SEX Male

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑

8. DATE OF BIRTH DEC. 1 1890

9. AGE (In years last birthday) 66

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) DAY LABORER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Mo

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME AUGUST BOLHOFNER

14. MOTHER'S MAIDEN NAME MARY SPINNER

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. 496-28-3908

17. INFORMANT Address ANN HOFFMANN 3891 BINGHAM

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arterio Sclerosis
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 9:50 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James M Kelly (Degree or title) Deputy Coroner

22b. ADDRESS 1300 Clark

22c. DATE SIGNED 12-15-56

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE DEC. 15 1956

23c. NAME OF CEMETERY OR CREMATORY ST. MATTHEWS

23d. LOCATION (City, town, or county) ST. LOUIS (State) Mo

24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois

25. DATE RECD. BY LOCAL REG. DEC 15 1956

26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was en

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....43

P. O. Address.....2906 B

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.