

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9240

STATE FILE NUMBER

FILED APR 1 - 1957 Registration District No. 172 Primary Registration District No. 4273 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <b>LAFAYETTE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>LAFAYETTE</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CONCORDIA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>CONCORDIA</b>		0540 0 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>412 LORINE ST</b>			Length of stay in ib		d. STREET (If outside, give location) ADDRESS <b>412 LORINE ST.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FREDRICK AUGUST</b> Last <b>BODENSTAB</b>			4. DATE OF DEATH Month <b>MAR</b> Day <b>24</b> Year <b>1957</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 26, 1879</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GEN FARMING</b>		11. BIRTHPLACE (City and state or country) <b>EMMA, MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>HENRY BODENSTAB</b>				14. MOTHER'S MAIDEN NAME <b>MATHILDA WELLNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Mrs ALVIN OKTING CONCORDIA, MO</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertensive cardiovascular disease with arricular fibrillation.</b>						Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>Oct 17, 1952</b> to <b>Mar 24, 1957</b> and last saw <b>him</b> alive on <b>Mar 24, 1957</b> . Death occurred at <b>6:25 p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Ultimacy, M. D.</b> (Degree or title)				22b. ADDRESS <b>Concordia, Mo</b>		22c. DATE SIGNED <b>3/25/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-27-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAUL'S</b>		23d. LOCATION (City, town, or county) (State) <b>CONCORDIA, MO</b>		
24. FUNERAL DIRECTOR ADDRESS <b>E. S. Jones Concordia, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>Mar. 26-1957</b>		26. REGISTRAR'S SIGNATURE <b>Mavis D. Bieby</b>		

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 causally related. Coroner cannot certify to a death due to natural causes.

Health, & Welfare  
Public  
Service

S. 300  
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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 me Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed E. S. James

Licensed Embalmer No. 205

P. O. Address Concordia

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.