

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15304

STATE FILE NUMBER 2842

FILED APR 29 1957

899

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY Stxxkxwts		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Overland Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glennon Hosp. Length of stay in lb 2 mo		21. STREET ADDRESS (If outside, give location) 9432 Romain Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Johu ANTHONY SONA First Middle Last			4. DATE OF DEATH Mar. 22 1957 Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 0 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ervin J. Sona		14. MOTHER'S MAIDEN NAME Mary Thomeczek	
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. None	17. INFORMANT Ervin Sona - 9432 Romaine Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO (b) Septicemia DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 1 day
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 0534		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 Jan 1, 1957 to Mar 15, 1957 and last saw ^{her} him alive on 3/15/57 Death occurred at 1030 am 3/22/57 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE G. J. Dubuque MD (Degree or title)		22b. ADDRESS 1325 S. GRAND	
22c. DATE SIGNED 3/22/57			
23a. BURIAL (CREMATION, REMOVAL) Burial		23b. DATE Mar 25 '57	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
24. FUNERAL DIRECTOR Al C. Ortmann Overland, Missouri ADDRESS		25. DATE RECD. BY LOCAL REG. MAR 23 '57	
26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.			

Health, Welfare & Public Service
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All symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
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.
SECURING THE MEDICAL CERTIFICATE IN THE SPECIFIC MANNER RECOMMENDED BY THE DIVISION OF HEALTH OF MISSOURI IS THE RESPONSIBILITY OF THE REGISTRAR.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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..

NOT EMBALMED

Student
Signature of Student Embalmer

Signed *Al C. O. Atmann*

Licensed Embalmer No. *347*

P. O. Address

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.