

FILED JAN 7 1958

Registration District No. 319

Primary Registration District No. 541

Registrar's No. 3110

300  
1-56

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residency before admission) a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>OVERLAND MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS CO HOSPITAL</u>		Length of stay in lb <u>3 DAYS</u>		d. STREET (If outside, give location) ADDRESS <u>2221 HOOD</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Adolph</u> Middle <u>HENRY</u> Last <u>Bollmeier</u>			4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>57</u>				
5. SEX <u>MALE</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-5-1875</u>	9. AGE (In years last birthday) <u>82</u>	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) <u>STREET COMMISSNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (City and state or country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FREDERICK BOHLMER</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>2221 HOOD</u> <u>EDITH BOHLMER OVERLAND MO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a); stating the underlying cause last.		DUE TO (b) <u>4200</u>					
		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malnutrition and dehydration</u>							19. WAS AUTOPSY PERFORMED? 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 <u>12-7-57</u> to <u>12-10-57</u> and last saw <sup>her</sup> <u>him</u> alive on <u>12-10-57</u> Death occurred at <u>5:15</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Robert J. Sawyer M.D.</u> (Degree or title)				22b. ADDRESS <u>601 So. Brentwood</u>		22c. DATE SIGNED <u>12-10-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>12-12-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKE CHARLES</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>		
24. FUNERAL DIRECTOR <u>Earl Alleman</u> ADDRESS <u>9109 BACKLAND</u>			25. DATE RECD. BY LOCAL REG. <u>12-10-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>		

**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 *E. J. Hollenman*

Licensed Embalmer No. *350*

P. O. Address *Orlando*

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.