

Health, Welfare, Public Service

FILED JAN 23 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2657

STATE FILE NUMBER

464

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST LOUIS</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>13 INCARNATE WORD HOSPI.</u>		Length of stay in 1b <u>2310</u>	d. STREET ADDRESS (If outside, give location) <u>2857 VICTOR</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E</u> Last <u>BOHN</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>13</u> Year <u>1958</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 1 1887</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>
--	---	---	--

13a. FATHER'S NAME <u>WILLIAM URBAN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>CHARLES BOHN (DEC'D)</u>
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>ROBERT BOHN 2857 VICTOR ST</u>	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) <u>Ch. nephritis Interstitial</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Diabetes Mellitus</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)		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 _____ Death occurred at _____ <u>Dec. 15</u> to <u>1/13/58</u> and last saw her alive on <u>1/12/58</u> <u>3:15 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>Carol Berglund</u> (Degree or title)	22b. ADDRESS <u>3203 S Grand</u>	22c. DATE SIGNED <u>1/13/58</u>
---	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN 15-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>
--	---------------------------------	---	---

24. EMBALMER DIRECTOR <u>Thomas Kutas</u> ADDRESS <u>2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 14 '58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

m & B.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 .....  
Licensed Embalmer No. 43471  
P. O. Address 2906 Howard

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.