

Health, Welfare, Public Service

FILED FEB 28 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-007195  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1382

300  
-57

0

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP.</u>		Length of stay in 1b <u>#1-2 Mos</u>	d. STREET ADDRESS (If outside, give location) <u>7418 PENNSYLVANIA</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BONNIE</u> Middle <u>FEIKERT</u> Last			4. DATE OF DEATH <u>FEB. 4, 1958</u> Month Day Year		
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>July 14, 1901</u>	9. AGE (In years last birthday) <u>56</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>MACHINE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAKOR HAT</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>? SKILES</u>		13b. MOTHER'S MAIDEN NAME <u>ANN ?</u>		14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or for unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>498-18-9576</u>	17. INFORMANT Address <u>JEAN GAVIN, 7217 PENNSYLVANIA</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>Congestive Heart failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Fibrotic atelectasis of @ lung - tbc margin</u> DUE TO (c) <u>Compensatory emphysema of @ lung.</u> 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
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.) <u>.002 x</u>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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>12/30/57</u> to <u>2/4/58</u> and last saw her/him alive on <u>2/4/58</u> Death occurred at <u>10:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Leo V. Mulligan</u> or title <u>Leo V. Mulligan M.D., M.D.</u>			22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>		22c. DATE SIGNED <u>2/4/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>2-5-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. TRINITY</u>		23d. LOCATION (City, town, or county) (State) <u>LEMAI 23, Mo</u>	
24. FUNERAL DIRECTOR <u>FENGLER UND. CO. 7420 Michigan</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>FEB 5 '58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> <u>mrb</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature. 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 *W. J. Peterson* .....

Licensed Embalmer No. *3767* .....

P. O. Address *7426 Milbija* .....

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.