THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001998
STATE FILE NUMBER

FILED FEB 9 1959 Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 13

1. PLACE OF DEATH
a. COUNTY Linn
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brookfield — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1017 Brookfield Ave. — Length of stay in 1b 3 wks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Kansas b. COUNTY Douglas
c. CITY OR TOWN Eudora 0346 0 — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First ELLA Middle Last BOHNSACK
4. DATE OF DEATH Month February Day 2 Year 1959

5. SEX F 1
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF DATE OF BIRTH April 12, 1882
9. AGE (In years last birthday) 76 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (City and state or country) Eudora, Kansas 1
12. CITIZEN OF WHAT COUNTRY? US

13a. FATHER'S NAME Dr. Alvin Schellack
13b. MOTHER'S MAIDEN NAME Rosa Kanzig
14. NAME OF HUSBAND OR WIFE A. J. Bohnsack

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 Dr. R. W. Bohnsack, Brookfield, Mo. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE GASTRIC HEMORRHAGE. — INTERVAL BETWEEN ONSET AND DEATH 24 hours.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) CARCINOMA of STOMACH — 4 Mo.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 151X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 11-20-58, to 2/2/59 and last saw her him alive on 2/2/59
Death occurred at 5:25 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. W. Bohnsack M.D. (Degree or title)
22b. ADDRESS 314 N. Main Brookfield Mo.
22c. DATE SIGNED 2/3/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Feb. 5, 1959
23c. NAME OF CEMETERY OR CREMATORY Eudora Cemetery
23d. LOCATION (City, town, or county) (State) Eudora, Kansas

24. FUNERAL DIRECTOR Wright Funeral Home, Brookfield, Mo. ADDRESS
25. DATE RECD. BY LOCAL REG. 2-5-59
26. REGISTRAR'S SIGNATURE Kathaline Johnson Dep.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, Mo.

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.