

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026418

FILED VS AUG 13 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's 2. 7206 STATE FILE NUMBER

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|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 353 Christian Ave Reside on Farm Y: <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|---|----------------------------------|---|---|---|---|----------------|
| 3. NAME OF DECEASED (Type or print) FRANK BENEDICT BOKAN | | | 4. DATE OF DEATH August 2nd, 1959 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11/20/84 | 9. AGE (last birthday) 74 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cabinet maker retired | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Jugoslavia | | 12. CITIZENSHIP OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Frank Bokan | | 13b. MOTHER'S MAIDEN NAME not known | | 14. NAME OF HUSBAND OR WIFE Katherine Bokan | | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. 488-09-2033 | 17. INFORMANT Katherine Bokan, 353 Christian | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Massive Gastrointestinal Hemorrhage | | |
| DUE TO (b) Peptic Ulcer | | |
| DUE TO (c) 540.0 | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized Arteriosclerosis | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____ | | |

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|--|--|---|--------|-------|
| 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 St. Louis, Mo. | COUNTY | STATE |
|--|--|---|--------|-------|

21. I attended the deceased from **August 1, 1959** to **August 2, 1959** last saw him alive on **August 2, 1959**
Death occurred at **7:45** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE Robert H. Kamey, M.D. | (Degree or title) | 22b. ADDRESS 25a S. Florissant Ferguson, Mo | 22c. DATE SIGNED 8/3/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | 23b. DATE 8/6/59 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 23d. LOCATION (City, town, or county) St. Louis, Mo. |

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| 24. FUNERAL DIRECTOR DIEDRICH FUNERAL HOME, 8519 Hallsberry | ADDRESS | 25. DATE RECD. BY LOCAL REG. AUG 4 '59 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

STATE OF MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH OFFICERS

THIS IS TO CERTIFY THAT THE BODY OF _____
DECEASED _____
ON _____
AT _____
CITY OF _____
COUNTY OF _____
STATE OF MISSOURI
WAS EMBALMED BY _____
A LICENSED EMBALMER
OR BY _____
A STUDENT EMBALMER
WORKING UNDER MY PERSONAL SUPERVISION.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St Louis

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.