

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-018401**

FILED VS MAY 31 1960

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|   |   |  |   |  |  |  |
|---|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Buchanan</u>  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>   |   | Length of stay in 1b <u>14 months</u>  | c. CITY OR TOWN <u>St. Joseph</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>Mo. Methodist Hospital</u>   |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <u>612 S. 6th St.</u>   |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>William</u> Middle _____ Last <u>Bohl</u>   |   |  | 4. DATE OF DEATH<br>Month <u>May</u> Day <u>19</u> Year <u>1960</u>   |  |  |  |
| 5. SEX <u>Male</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>Sept. 16, 1907</u>  | 9. AGE (last birthday) <u>58</u>   | IF UNDER 1 YEAR<br>Months _____ Days _____   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Salvation Army Store</u>  | 11. BIRTHPLACE (City and state or country) <u>Chicago, Illinois</u>   |  | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>  |  |
| 13a. FATHER'S NAME <u>Not known</u>   |   | 13b. MOTHER'S MAIDEN NAME <u>Not known</u>   |   | 14. NAME OF HUSBAND OR WIFE <u>Not known</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>322-12-4423</u>   | 17. INFORMANT <u>Salvation Army records St. Joseph, Mo.</u><br>Address _____  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ruptured Esophageal Varcies</u>  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u>                                       |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cirrhosis of the Liver</u>   |   |  |   |  | Unk.   |  |
| DUE TO (c) _____  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |   |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
| 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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____   |   |  |   |  |  |  |
| 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>5/11/60</u> to <u>5/19/60</u> and last saw him alive on <u>5/18/60</u><br>Death occurred at <u>12:30 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |   |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><u>W.D. Craig M.D.</u>  |   |  | 22b. ADDRESS <u>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</u>  |  | 22c. DATE SIGNED <u>5/20/60</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE <u>May 21, 1960</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Public Cemetery</u>  |   | 23d. LOCATION (City, town, or county) <u>St. Joseph, Mo.</u>   | (State)  |  |
| 24. FUNERAL DIRECTOR <u>Clark Funeral Home</u>  |   | ADDRESS <u>St. Joseph, Mo.</u>   | 25. DATE RECD. BY LOCAL REG. <u>May 20, 1960</u>  | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clara Stoddell</u>   |  |  |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

W.D. Craig, M.D.

**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 *Ernest Clark*

Licensed Embalmer No. 4238

P. O. Address *Spring*

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.