

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-024337**

**FILED VS JUN 27 1960**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6123**

STATE FILE NUMBER

|   |   |   |  |  |  |  |  |
|---|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |  |  |  |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>  |   | Length of stay in lb<br><b>30 Yrs.</b>  |  | c. CITY OR TOWN <b>St. Louis</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>5362 Wabada Ave.</b>  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>5362 Wabada Ave.</b>   |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Laura</b> Middle <b>Bohnenstiehl</b> Last   |   |   | 4. DATE OF DEATH<br>Month <b>6</b> Day <b>13</b> Year <b>1960</b>                    |  |  |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/18/67</b>   | 9. AGE (last birthday)<br><b>93</b>  | IF UNDER 1 YEAR<br>Months Days Hours                               | IF UNDER 24 HR<br>Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>Troy, Ill.</b>  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME<br><b>Louis Schultz</b>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  | 14. NAME OF HUSBAND OR WIFE<br><b>William Bohnenstiehl</b>         |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT Address<br><b>Pearl Bohnenstiehl, 5362 Wabada</b>  |  |  |  |
| 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) <b>Arteriosclerotic Heart Disease.</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <b>Arteriosclerosis, generalized</b><br>DUE TO (c) <b>420.0</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs.</b><br><b>10 yrs.</b>                  |  |
| 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 <b>10-24-57</b> to <b>6-13-60</b> and last saw her alive on <b>5-16-60</b> .<br>Death occurred at <b>6 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |  |  |  |  |  |
| 22a. SIGNATURE <b>D. Todd Forsyth</b> (Degree or title)<br><b>M.D. M.D.</b>   |   |   |  | 22b. ADDRESS <b>3720 Washington</b><br><b>3720 Wabada St. Louis 8 Mo</b>   |  |  | 22c. DATE SIGNED<br><b>6-15-60</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>   | 23b. DATE<br><b>6/16/60</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Friedens Cemetery</b>  |  | 23d. LOCATION (City, town, or county)<br><b>St. Louis County Mo.</b>   |  |  | (State)  |
| 24. FUNERAL DIRECTOR<br><b>Drehmann-Harral, 1905 Union Blvd.</b>  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>JUN 15 1960</b>                                   |  | 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith, M.D.</b><br><b>mde</b> |  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Warren A. Carr

Licensed Embalmer No. 353

P. O. Address \_\_\_\_\_

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.