

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-012472

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District **1003** Registrar's No. **2919**

FILED MAR 26 1962

VS 300
Rev. 4/59

1	
2	217
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4	1
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.		b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4451 Russell Ave.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4451 Russell Ave.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRACE Middle BOLHAFNER Last BOLHAFNER						4. DATE OF DEATH Month Mar. Day 16 Year 1962							
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1-10-1890		9. AGE (last birthday) 72		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Government Vet. Adm. Employee				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Mt. Carmel, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME John Rectar				13b. MOTHER'S MAIDEN NAME Annie Calhoun				14. NAME OF HUSBAND OR WIFE Late Robert Bolhafner					
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. None		17. INFORMANT Address Mrs. C. C. Lamme 4060 Phillips Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction												INTERVAL BETWEEN ONSET AND DEATH 10 mos	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 420-1													
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. <input type="checkbox"/> Yes <input checked="" 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 Hour _____ a.m. _____ p.m.		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 Nov 22 1978 to Mar 15 1962 and last saw her Mar 15 62 alive on _____ Death occurred at 1:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE J. W. Henderlite M.D.						22b. ADDRESS 4500 Olive St St Louis Mo			22c. DATE SIGNED 3-16-62				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Mtr)		23b. DATE Mar. 17, 1962		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Vandalia, Mo.							
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.						25. DATE RECD. BY LOCAL REG. MAR 16 1962		REGISTRAR'S SIGNATURE Loard Smith. M.D.					

USE BLACK INK OR TYPEWRITER RIBBON

Dr. John W. Henderlille
4500 Olive St.
10:00 - 12:30
Po. 7-3824

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 William B White

Licensed Embalmer No. 7291

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.