

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County *St. Louis*
Township *Jefferson*
or
Village
or
City

Registration District No.

360

File No.

31246

Primary Registration District No.

6092

Registered No.

(NO.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Lloyd R. Bockmann

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>✓</i>
6 DATE OF BIRTH <i>Sept 14 1918</i> (Month) (Day) (Year)		
7 AGE <i>1</i> yrs. <i>1</i> mos. <i>16</i> ds.		If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <i>Missouri</i>		
PARENTS	10 NAME OF FATHER <i>R. B. Bockmann</i>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <i>Ill</i>	
	12 MAIDEN NAME OF MOTHER <i>Myrtle Slauer</i>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <i>Ill</i>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. L. Bockmann

(Address)

Clayton

15

Filed

J. A. Hyatt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 30
(Month) (Day)

1918
(Year)

17 I HEREBY CERTIFY, that I attended deceased from *Sept 14*, 1918, to *Sept 30*, 1918, that I last saw him alive on *Sept 30*, 1918, and that death occurred, on the date stated above, at *9:30 P.* m.

The CAUSE OF DEATH* was as follows:

Infantile Birth
1918

CONTRIBUTORY

(Secondary)

(Duration)

yrs.

mos.

ds.

(Duration)

yrs.

mos.

ds.

(Signed)

Dr. Brand

M. D.

1918

(Address)

Drucan Bridge

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Union

DATE OF BURIAL

10-1-1918

20 UNDERTAKER

E. C. Hopper

ADDRESS

Clayton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

1 PLACE OF DEATH

County
Township
or
Village
or
City
Registration District No. File No.
Primary Registration District No. Registered No.
(NO) St. Ward
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH	 (Month) (Day) 191..... (Year)	
7 AGE	 yrs. mos. ds. If LESS than 1 day, ... hrs. min.?	

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(City or town, State or foreign country)

10 NAME OF FATHER	11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed 191.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) (Day) 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191..... to 191.....
that I last saw h..... alive on 191.....
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

.....

..... (Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) M. D.

..... 191..... (Address)

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191.....

20 UNDERTAKER

ADDRESS