

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

Do not use this space.

JAN 28 1928

42402

1. PLACE OF DEATH
 County St. Louis Registration District No. 790
 Township Central Primary Registration District No. 60250
 City Manchester (No. 8200 Manchester Rd) St. _____ Ward _____

2. FULL NAME John K. Stocker
 (a) Residence No. 7432 Maple St. Maplewood Mo.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ellie Stocker
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 16 1885
 7. AGE YEARS MONTHS DYS If LESS than 1 day, hrs. or min.
44 | 6 | 22 | 0 | 0 | 0
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Chauffeur
 (b) General nature of industry, business, or establishment in which employed (or employer) St. Louis County School
 (c) Name of employer St. Louis Co. Mo.
 9. BIRTHPLACE (CITY OR TOWN) St. Louis Co. Mo.
 (STATE OR COUNTRY)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 25 1928
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 19____, m. 8:20
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fractured skull. 2 1/2"
Automobile accident - at
Brentwood Mo, about 8200
Manchester Road yrs. mos. da.
 CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.
 18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH: _____

PARENTS
 10. NAME OF FATHER James Stocker
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Sarah Godfrey
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

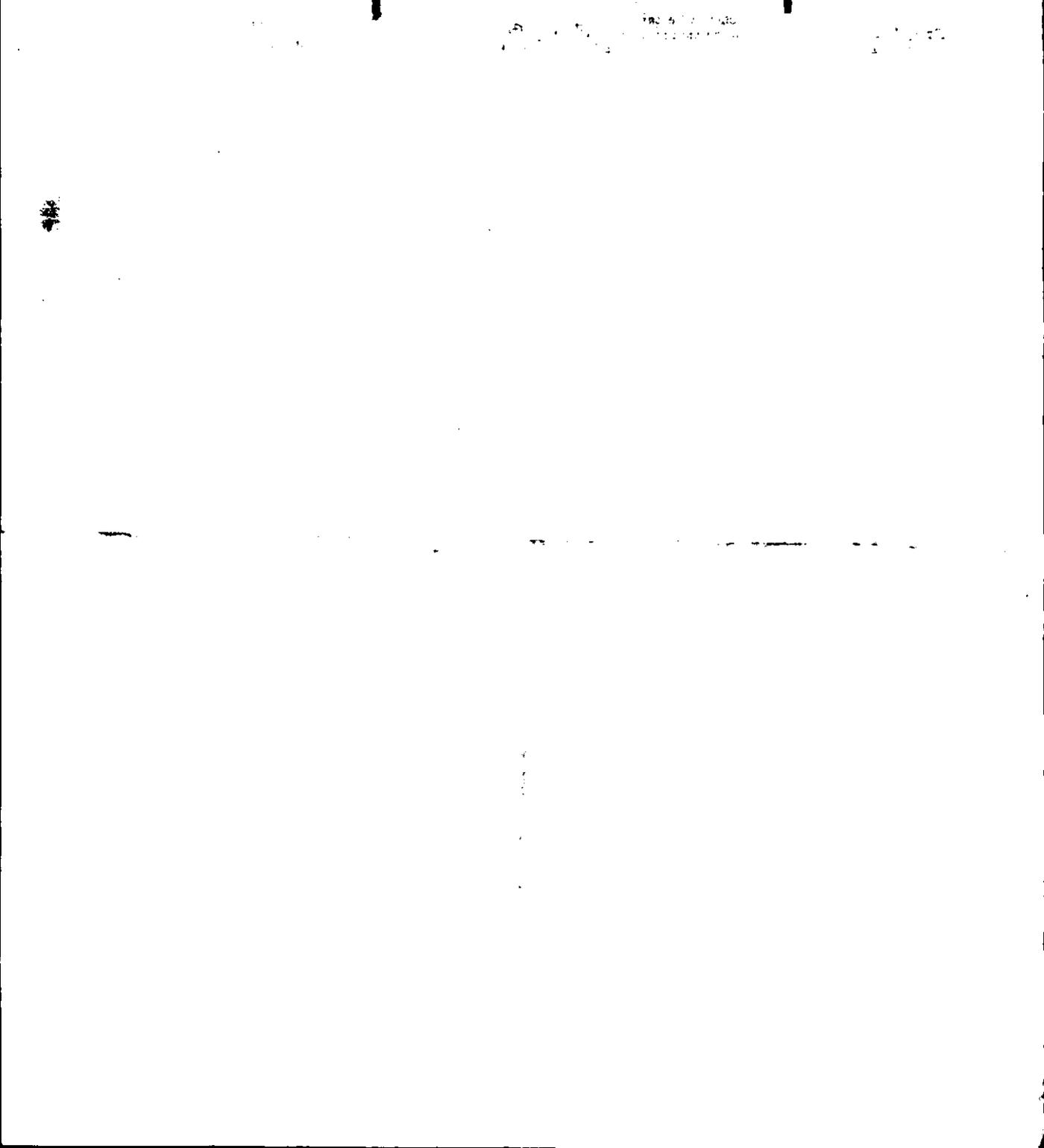
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS? Autopsy - Negative skull
 (Signed) John E. Shumaker _____, M. D.
 (Address) Coroner of St. Louis County
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT Robert Stocker
 (Address) 8230 Manchester Rd
 15. FILED Dec 25 1928 Katherine W. Sullivan
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bellefontaine Cem DATE OF BURIAL 12/29 1928
 20. UNDERTAKER Broghan - 2142 Manchester ADDRESS

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.

43-5-9



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis
Township Central
City (No.) St. Ward)

Registration District No. 990
Primary Registration District No. 6033

File No.
Registered No.

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 16 - 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 5 9

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED..... 19 1 Katherine M. Sullivan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 25 1928

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above of..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. ds.
PRIMARY.....
SECONDARY..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. B.—Every item of information 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. REGISTRARS SHALL NOT RECEIVE COPIES OF CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-42402