

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

Do not use this space.

43108

**1. PLACE OF DEATH**

County.....

Registration District No. 70A

Township.....

Primary Registration District No. 1008

City St. Louis

(No. Jewish Hospital)

St. \_\_\_\_\_ Ward)

File No. \_\_\_\_\_

Registered No. 12400

**2. FULL NAME**

Robert Blochseman

(a) Residence. No. 1641 Arlington St. 6 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**

Male

**4. COLOR OR RACE**

white

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Married

**5A. IF MARRIED, WIDOWED, OR DIVORCED**

HUSBAND OF (OR) WIFE OF Ida Bochsman

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Unknown

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

About 65

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Russia

**10. NAME OF FATHER** Ben Bochsman

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

**12. MAIDEN NAME OF MOTHER** Unknown

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

**14. INFORMANT** Max Bochsman

(Address) 1641 Arlington

**15. FILED** DEC 19 1928 W. C. Walker REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 12-19-1928

**17. I HEREBY CERTIFY**, That I attended deceased from December 15<sup>th</sup>, 1928, to Dec 16, 1928 that I last saw h.i.m. alive on December 19, 1928, and that death occurred, on the date stated above, at 1846 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Streptococci infection of right thigh, and involving tibial bone running into blood infection following (duration) yrs. 2 mos. - ds.

**CONTRIBUTORY (SECONDARY)** Cardiac failure (duration) yrs. - mos. - ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH. at home

**19. DID AN OPERATION PRECEDE DEATH?** Yes DATE OF Dec 17-28

**20. WAS THERE AN AUTOPSY?** NO

**WHAT TEST CONFIRMED DIAGNOSIS?** Blood culture

(Signed) J. H. Marks, M. D. (Address) 70 Jewish Hosp.

\*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**

Philadel Smith Cemetery

**DATE OF BURIAL**

Dec 20 1928

**20. UNDERTAKER**

Human Rindshoff

**ADDRESS**

5216 Delmar Pl.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

