

APR 12 1939

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

Do not use this space.

16411

1. PLACE OF DEATH

County Washington Registration District No. 886
Township Hopewell Primary Registration District No. 6178
City (No.) St. Ward

File No. 16411
Registered No. 7

2. FULL NAME

Barbara Jean Bockenkamp **BOCKENKAMP**

(a) Residence, No. Hopewell St. Ward.

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 10, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from Apr. 11 - 1939, to Apr. 10, 1939.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-14-1938

I last saw her alive on Apr. 11, 1939. Death is said to have occurred on the date stated above, at 10²⁵ P. m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 0 6 1

The principal cause of death and related causes of importance were as follows:

Broncho-Pneumonia Date of onset 4-13-39

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

Other contributory causes of importance: Inanition

12. BIRTHPLACE (CITY OR TOWN) X St. Louis Mo (STATE OR COUNTRY)

13. NAME X Andrew Bockenkamp

Name of operation Date of What test confirmed diagnosis? Clinical Was there an autopsy? No.

14. BIRTHPLACE (CITY OR TOWN) X Bonne Terre Mo (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19... Where did injury occur? (Specify city or town, county, and State)

15. MAIDEN NAME X Blanche Sullivan

Specify whether injury occurred in industry, in home, or in public place. Manner of injury Nature of injury

16. BIRTHPLACE (CITY OR TOWN) X Kaso Ill. (STATE OR COUNTRY)

17. INFORMANT X Hopewell Mo (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Hopewell Mo DATE April 17, 1939

19. UNDERTAKER Progen White & Sons (ADDRESS) Hopewell Mo

24. Was disease or injury in any way related to occupation of deceased? No. If so, specify (Signed) R. B. Reiter, M. D. (Address) DeLoze Mo.

20. FILED 6-16, 1939 J. P. Geary Registrar.

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

1092

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

16411
Do not use this space.

1. PLACE OF DEATH

(a) County Washington Registration District No. 886
 (b) Township Concord Primary Registration District No. 6178 Registered No. _____
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Barbara Jean Bokenkamp
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>7</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>S</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS	MONTHS
		<u>6</u>
		<u>1</u>
		If LESS than 1 day, _____ hr. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
FATHER	13. NAME	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE	DATE	19
19. FUNERAL DIRECTOR (ADDRESS)		
20. FILED _____, 19 _____		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 15, 1979

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Bacterial Pneumonia
Primary, uncomplicated.
 Date of onset _____

Other contributory causes of importance:
Fracture 10/12

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) R. B. Lester, M. D.
 (Address) Desloge mo.

SUPPLEMENTARY

Local Registrar.

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

