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

25052
Do not use this space.

1. PLACE OF DEATH
(a) County Gasconade Registration District No. 303
(b) Township or City ROARK (Hermann R#2) Primary Registration District No. 5420 Registered No.
(c) City (Hermann R#2) (d) Street No. St.
(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 OTTO H. BOCK
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male | 4. COLOR OR RACE White | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 5-1873

7. AGE: Years 67 | Months 9 | Days 3 | If LESS than 1 day, ...hrs. 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. Retired
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) Stolpe Mo

FATHER
13. NAME Carl Bock
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER
15. MAIDEN NAME Westmann
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Mrs. E. Bock

18. BURIAL, CREMATION, OR REMOVAL PLACE Stolpe DATE 8/11/41

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. Rieckhoff

20. FILED 8-10-1941 Anna K. Rieckhoff Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/8/41, 19

22. I HEREBY CERTIFY, That I attended deceased from March 1, 1941 to August 8, 1941
I last saw him alive on August 2, 1941. Death is said to have occurred on the date stated above, at 8:00 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Parkinson's disease	1930

Other contributory causes of importance:

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

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? No.
If so, specify
(Signed) E. J. Wessling M. D.
(Address) Hermann, Mo

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.

(Licensed Embalmer's Statement on Reverse Side)

SEP 31

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 Mayse

....., Registered Apprentice No.....

working under my personal supervision.

Signed C. R. Redding

Licensed Embalmer No. 2044

P. O. Address Hermann Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
M—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25052

Registration District No. 303 Primary Registration District No. 5420 Registrar's No.

1. PLACE OF DEATH:
(a) County Gasconade
(b) City or town Roark Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Gasconade
(c) City or town Stolpe (Rural P.O.)
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No - (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Otto H. Bocke
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 6-10-41 (Date received local registrar) (b) Anna K. Rickhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6
year 1941 hour 1 minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-25052