

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15254

State File No.

Registrar's No. 251

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

X32873

FILED MAY 7 1943

Registration District No. ... Primary Registration District No. 6075

1. PLACE OF DEATH:

(a) County St. Francois Co
 (b) City or town Farmington, RURAL S. 3 mi. N. W. 1/4 Sec. 12, T. 22 N., R. 10 W., S. 12 E., Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
No State Hospital No. 1 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 yr 26 Das
(Specify whether years, months or days)

3. (a) PRINT FULL NAME ALVINA GOCKEL

3. (b) If veteran, name war. 3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Single
 6. (b) Name of husband or wife. None 6. (c) Age of husband or wife if alive. None years
 7. Birth date of deceased March 24 1876
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 11 If less than one day hr. min.

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

10. Usual occupation House Maid

11. Industry or business House Maid

12. Name Anton Gockel
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Camoline Bedford
 15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 4-7-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hosp. Cem. Farmington, Mo.

18. (a) Signature of funeral director C. H. Cozean

(b) Address Farmington, Missouri

19. (a) April 10, 1943 (b) Byrdie Buhrmester
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
 (c) City or town Cape Girardeau County Home
(If outside city or town limits, write "RURAL")
 (d) Street No. R. F. D.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th year 1943 hour 7 minute 10 P. M.
 21. I hereby certify that I attended the deceased from 19..... to 19.....
 that I last saw her alive on April 5th 1943 and that death occurred on the date and hour stated above.
 Immediate cause of death Pneumonia 40 Das.

Due to Infirmities of old age
 Due to Psychosis with cerebral arteriosclerosis.
 Other conditions.
(Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy No 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)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? (Specify type of place)
 (e) Means of injury
 23. Signature Lillian Burchard (M. D. or other)
 Address State Hospital # 4 Date signed 7-6-43

District Health Officer No. 4
District File Number 543-273
Date Filed 5-5-43

STATEMENT BY LICENSED EMBALMER

not

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

m

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

working under my personal supervision.

Signed..... *W. H. Cozart*

Licensed Embalmer No. 4084

P. O. Address Farmington

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St Francois

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Mo. St. Hosp. #4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Alvina Cackel

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Feb 24 - 1876
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days _____ (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr Day 5 Year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia lobar

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration 10 da

PHYSICIAN 108

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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

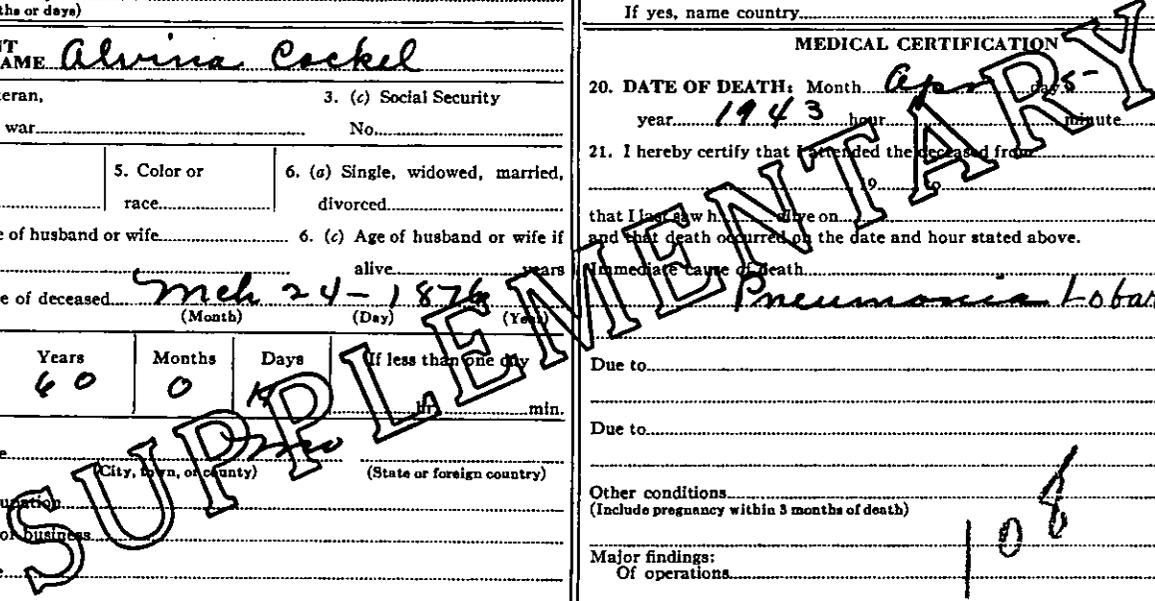
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER



S-15254