

FILED SEP 8 1944
Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 Days (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Henrietta Olivia Bocclair

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 7 15 44
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name William Horace Bocclair
13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Dorothy Lee Eddins
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Esther M. Sward, R.N.
(b) Address 2601 N. Whittier Street

17. (a) Burial (b) Date thereof AUG 20 1944
(Burial, cremation, or removal) (City or town) (County) (State)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director James Owens
(b) Address City Health Dept

19. (a) AUG 20 1944 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4552a Enright Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 24
year 44 hour 3 minute 05 PM.

21. I hereby certify that I attended the deceased from 7 - 15
1944 to 7 - 24, 1944
that I last saw her alive on 7 - 24, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Prematurity
Due to Unknown
Due to Unknown

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

Major findings: _____ PHYSICIAN _____
Of operations _____ Underline the cause to which death should be charged statistically.
Of autopsy _____

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature W. H. Sibley (M. D. or Dentist)
Address 2601 Whittier Date signed 8-21-44

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

..... Licensed Embalmer No.....

..... P. O. Address.....

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.