

No. 2
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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3996

State File No. _____

#28078
FILED MAR 9 1945

318

Registration District No. _____ Primary Registration District No. 1006

Registrar's No. 1690

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Memorial St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 Days
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Mo (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4509 Manchester Ave
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Louis Bockoff

3. (b) If veteran, name war No

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 18,
year 1945 hour 3:30 minute P. M.

21. I hereby certify that I attended the deceased from February 6, 1945, to February 18, 1945, that I last saw him alive on February 18, 1945, and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mae

6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased Oct 12 1906
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Lung

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) Central Metastasis

8. AGE:	Years	Months	Days	If less than one day
	<u>38</u>	<u>4</u>	<u>6</u>	hr. _____ min. _____

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

10. Usual occupation Electrician

11. Industry or business City Lighting Dept

MOTHER FATHER

12. Name Lorenz Bockoff

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Mary Siebert

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

Major findings: Of operations

Of autopsy same

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mae Bockoff

(b) Address 4509 Manchester Ave

17. (a) Burial (b) Date thereof 2 21 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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? _____

18. (a) Signature of funeral director KRIEGSHAUSER

(b) Address 4228 So. Kingshighway

19. (a) FEB 20 1945 (Date received local registrar)

J. F. Bredek (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature James J. South (M. D. or other)

Address 1515 Lafayette Date signed 2/19/45

(Licensed Embalmer's Statement on Reverse Side)

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

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

Edwin D. Mc Dermott

Licensed Embalmer No.

3024

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.