

Registration District No. 229

Primary Registration District No. 3870

Registrar's No. 1986

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Webster Groves  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
140 W. Swon 1  
(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 MO (b) County St. Louis  
(c) City or town Webster Groves  
(If outside city or town limits, write "RURAL")  
(d) Street No. 140 W. Swon  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Stocker  
3. (b) If veteran name war None 3. (c) Social Security No. 499-05-8710

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 21 year 1945 hour 6 minute 30 P.M.

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Frances Clayton Stocker 6. (c) Age of husband or wife if alive 30 years  
7. Birth date of deceased Jan 30 1887  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from week \_\_\_\_\_, 19\_\_\_\_, to 12/21/45, 19\_\_\_\_; that I last saw him alive on 12/21/45, 19\_\_\_\_; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>11</u>	<u>21</u>	hr. _____ min. _____

Immediate cause of death Carcinoma of throat & neck  
Due to 45 f  
Due to \_\_\_\_\_

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name Frederick Stocker  
13. Birthplace Germany (City, town, or county) (State or foreign country)  
14. Maiden name Johanna Neuberger  
15. Birthplace Germany (City, town, or county) (State or foreign country)

Major findings: Of operations none  
Of autopsy none  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Francis Stocker  
(b) Address 140 W. Swon Webster Groves  
17. (a) Burial (b) Date thereof 12-24-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lake Charles Cem

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) none  
(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 Louis St. Bopp  
(b) Address Kentwood Mo  
19. (a) 12-28-45 (b) W. M. Gordon MD  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Frank S. Gant (M. D. or other) MD  
Address 13<sup>th</sup> N. Gore, Webster Groves Date signed 12/21/45

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.....

*Felix Durand*

Licensed Embalmer No.....

*3034*

P. O. Address.....

*Kirkwood Mo*

**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.**

Registration District No. 317

Primary Registration District No. 3520

**1. PLACE OF DEATH:**  
(a) County St Louis  
(b) City or town W. Chester Grove  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

**3. (a) PRINT FULL NAME** William Stoeker  
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 m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Jan 30 1958  
(Month) (Day) (Year)

**8. AGE:** Years 58 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Supervisor

11. Industry or business State of Missouri

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

**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 \_\_\_\_\_

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month Jan Day 30 Year 1958 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

**PHYSICIAN**  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_

SUPPLEMENTARY

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

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