

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED FEB 3 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 605

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3737a Ohio /  
(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

3. (a) PRINT FULL NAME William Gockel Sr.

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 499-01-2529

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

6. (b) Name of husband or wife Katie Gockel 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Sept. 17 1872  
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired Clerk  
St. Louis Title Co.

11. Industry or business William Gockel

12. Name unknown Germany 4

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

14. Maiden name Unknown

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

16. (a) Informant Katie Gockel

(b) Address 3737a Ohio

17. (a) Burial (b) Date thereof 1/19/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn

18. (a) Signature of funeral director Wacker-Hildeck

(b) Address 3634 Gravois Ave.

19. (a) JAN 19 1946 (b) J. F. Braseck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3737a Ohio (If rural, give location) 24  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 17 1946  
year 1946 hour 6 minute 45 A. M.

21. I hereby certify that I attended the deceased from Jan 1 1946 to Jan 17 1946  
that I last saw him alive on Jan. 17 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Showing my records

Due to Influenza Duration 10 days

Due to \_\_\_\_\_

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

Major findings: Of operations None

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? \_\_\_\_\_

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

23. Signature Julius John Keller (M. D. or other) M.D.

Address 2603 Cherokee St Date signed 1/18/46

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

2539

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**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..... 26757

P. O. Address..... St. Louis, 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.**