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

FEDERAL SECURITY AGENCY
[redacted] SEP 13 1948
Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 1003

State File No. 27545
Registrar's No. 7521

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: Good Samaritan Home 4500 Washington 4 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution About 5 months (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 600
(a) State Missouri (b) County 17
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 9
(d) Street No. 4500 Washington Ave (If rural, give location) 0
12
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Catherine H. Bockstruck
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife William F. Bockstruck
6. (c) Age of husband or wife if alive ------ years
7. Birth date of deceased March 27, 1874 (Month) (Day) (Year)

8. AGE: Years 74 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation At home
11. Industry or business

MOTHER FATHER
12. Name William Tibbe 4
13. Birthplace Unknown (City, town, or county) Holland (State or foreign country) 4
14. Maiden name Catherine Gausmann
15. Birthplace Unknown (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Robert W. Bockstruck
(b) Address 1633 Goodman Ave Cincinnati 24 Oh 18
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/48 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters Cemetery
18. (a) Signature of funeral director Math Hermann & Son, Inc.
(b) Address 2161 East Fair Ave
19. (a) AUG 27 1948 (Date received local registrar) (b) Jos. J. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug. day 26th year 1948 hour 7:45 AM minute M.
21. I hereby certify that I attended the deceased from Aug 4, 1948, to Aug 26, 1948, that I last saw her alive on Aug 24, 1948, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebro-vascular disease.	
Due to: 82	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Primary anemia.	

Major findings:
Of operations
Of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. F. Bergmann (M. D. or other) M.D.
Address 332 S. Washington Date signed 8/26/48

(Licensed Embalmer's Statement on Reverse Side)

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 Glen W. Hatz

Licensed Embalmer No. 3737

P. O. Address 2161 E. Fair Ave

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.