

FILED OCT 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34598
State File No.
Registrar's No. 8641

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 62 Yrs		2209	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2510 Benton St.		d. STREET ADDRESS (If rural, give location) 20 2510 Benton	

3. NAME OF DECEASED (Type or Print) Herman H Bockewitz			4. DATE OF DEATH (Month) (Day) (Year) 10 12 50					
5. SEX 0 Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /	8. DATE OF BIRTH 8-21-1886	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ILL		12. CITIZEN OF WHAT COUNTRY?		

13a. FATHER'S NAME Carl Bockewitz	13b. MOTHER'S MAIDEN NAME Minnie Peeper	14. NAME OF HUSBAND OR WIFE Edna Bockewitz
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) # 1	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 498-40-6527	17. INFORMANT'S SIGNATURE OR NAME Mrs. Edna Bockewitz	ADDRESS 2510 Benton St
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-vascular-renal disease		INTERVAL BETWEEN ONSET AND DEATH 11/30/42 and 8 hours.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) cerebral hemorrhage		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? HHTX
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22. I hereby certify that I attended the deceased from Nov. 30, 1942, to Oct. 11, 1950, that I last saw the deceased alive on Oct. 11, 1950, and that death occurred at 1:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE William H. Grundmann MD	(Degree or title)	22b. ADDRESS 3118 N. Grand St. S.d.m. (7)	22c. DATE SIGNED Oct. 12, 1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-14-50	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Co.
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DATE REC'D BY LOCAL REG. OCT 13 1950	REGISTRAR'S SIGNATURE J B Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Goodhart & Goodhart	ADDRESS 2228 St. Louis, Av.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

01111P

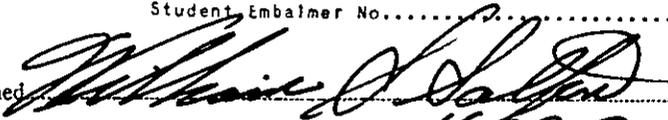
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

working under my personal supervision.

Student Embalmer No.

Signed



Signed.....
Student Embalmer

Licensed Embalmer No. 1699

P. O. Address St. Charles, 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.