

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30584**

4092
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FILED AUG 25 1953

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **2170**

1. PLACE OF DEATH a. COUNTY ST. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY ST. Louis	
b. CITY OR TOWN CLAYTON		c. CITY OR TOWN Websier Groves	
c. LENGTH OF STAY (In this place) 20 Days		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. Louis Co. Hospital		e. STREET ADDRESS (If rural, give location) 729 Newport Ave	

3. NAME OF DECEASED (Type or Print) a. (First) LOUISE	b. (Middle)	c. (Last) BOCKERS	4. DATE OF DEATH (Month) (Day) (Year) Aug. 6, 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7-25-1871	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and State or Foreign Country) ST. Louis Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Henry Plasmeyer	13b. MOTHER'S MAIDEN NAME not known	14. NAME OF HUSBAND OR WIFE Peter Bockers
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Bruce McLean	ADDRESS 729 Newport
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 1 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **July 17, 1953**, to **Aug. 6, 1953**, that I last saw the deceased alive on **Aug. 6, 1953**, and that death occurred at **2:57pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Charles E Brodine M.D.	23b. ADDRESS 601 S. Brentwood, Clayton	23c. DATE SIGNED 8-7-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Buried	24b. DATE 8-8-53	24c. NAME OF CEMETERY OR CREMATORY New Picker Cem	24d. LOCATION (City, town, or county) (State) St. Louis Mo
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DATE REC'D BY LOCAL REG. 8-7-53	REGISTRAR'S SIGNATURE Herbert R. Danaher M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Kron Lou Co	ADDRESS 2707 N. Grand
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WRITE PLAINLY—USING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Ben Hoffman*.....

Licensed Embalmer No. *438*.....

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

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.