

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37182
STATE FILE NUMBER
9586

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS 5727 Nottingham Ave	
3. NAME OF DECEASED (Type or print) First ALVIN Middle J. Last BOCKWINKEL SR.		4. DATE OF DEATH Month Day Year Oct. 13 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1903
9. AGE (In years last birthday) 54		10. KIND OF BUSINESS OR INDUSTRY Claim Adjustor-General	
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Bockwinkel		14. MOTHER'S MAIDEN NAME Anna Poeling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address (Wife) Ellenor S. Bockwinkel 5727 Notting-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) <i>oik. gangrene</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>gangrene</i>			INTERVAL BETWEEN ONSET AND DEATH 7 hours UNKNOWN
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>10/15/57</i>
20c. TIME OF INJURY a. m. p. m.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 13 Oct 57 to 13 Oct 57 and last saw her alive on 13 Oct 57 Death occurred at 5:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John J. McCann M.D.		22b. ADDRESS 4401 HAMPTON	22c. DATE SIGNED 14 Oct 57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct. 16, 1957	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway		25. DATE RECD. BY LOCAL REG. OCT 14 57	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>

(Licensed Embalmer's Statement on Reverse Side)

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

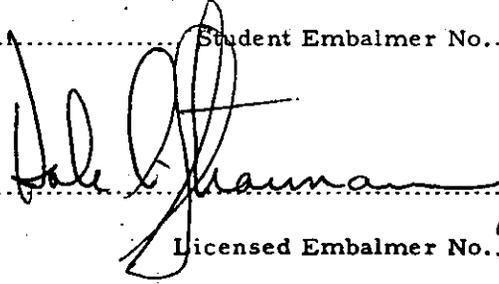
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

OCT 30 1957

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  Student Embalmer No. Licensed Embalmer No. 453

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.