

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033589

FILED VS SEP 21 1959

2 8211

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ 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	
Length of stay in, 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3900A McDONALD		d. STREET ADDRESS (If outside, give location) 3900A McDONALD	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MINNIE Middle H Last BOCKSTRUCK			4. DATE OF DEATH Month SEPT Day 4 Year 1959			
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/29/1873	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR 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	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME DENNIS STOCK	13b. MOTHER'S MAIDEN NAME THERESA HAKKE	14. NAME OF HUSBAND OR WIFE HENRY
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT CECELIA COPPEDGE McDONALD	Address 3900A
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emaciation-dehydration carcinoma of rt. kidney - cystitis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Emaciation due to dehydration DUE TO (c) Carcinoma of right kidney & Cystitis		INTERVAL BETWEEN ONSET AND DEATH 4 mo 4 mo
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 180+	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	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 _____
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21. I attended the deceased from Feb 27 59 to Sept 4 59 and last saw her/him alive on Sept 2 59 Death occurred at 7:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE Walter Bidmann (Degree or title) <i>Walter Bidmann M.D.</i>	22b. ADDRESS 3116 Morganford <i>3116 Morganford</i>	22c. DATE SIGNED 9-4-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 9/7/1959	23c. NAME OF CEMETERY OR CREMATORY ZION CEMETERY	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR J L ZIEGENHEIN & SONS	ADDRESS 7027 GRAVOIS	25. DATE RECD. BY LOCAL REG. SEP 4 1959	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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, Donald E. Bevis

Licensed Embalmer No. 4863

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.