

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-044635

FILED VS NOV 28 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3257

DED

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| 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 (If outside corporate limits, give TOWNSHIP only) OR TOWN Des Peres | | Length of stay in lb 10 mo. | c. CITY OR TOWN Kirkwood Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Ozark Nursing Home | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 900 Bernice Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Valeria Middle E. Last Bockhorst | | | 4. DATE OF DEATH Month November Day 8 Year 1960 | | | |
| 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 11/9/1878 | 9. AGE (last birthday) 81 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (City and state or country) Wright City, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S. |
| 13a. FATHER'S NAME Nathan Kennedy | | 13b. MOTHER'S MAIDEN NAME Mary Gilkey | | 14. NAME OF HUSBAND OR WIFE William W. Bockhorst | | |
| 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 Address Roland W. Bockhorst, 900 Bernice | | |

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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) Arteriosclerosis heart disease | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs? | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis | | | 2 yrs.? |
| DUE TO (c) unknown | | | |

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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) Cerebral Arteriosclerosis | | 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.) | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ | Month, Day, Year _____ | | |

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|---|--|---|--------------------------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION Wright City, Mo. | COUNTY _____ STATE _____ |
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21. I attended the deceased from 1 day to 11/8/60 and last saw her live on 11/8/60
Death occurred at 8:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>J. H. Barnett</i> | (Degree or title) | 22b. ADDRESS 1042 1/2 Manufactured Richmond, Mo. | 22c. DATE SIGNED 11/9/60 |
|--|-------------------|--|------------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 11-11-60 | 23c. NAME OF CEMETERY OR CREMATORY Local Cemetery | 23d. LOCATION (City, town, or county) (State) Wright City, Mo. |
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| 24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd. | 25. DATE RECD. BY LOCAL REG. 11-9-60 | 26. REGISTRAR'S SIGNATURE <i>J. C. Murphy</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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 459

P. O. Address St Louis

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