

MISSOURI DIVISION OF HEALTH AND WELFARE - STANDARD CERTIFICATE OF DEATH

-61-046089

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Primary Registration District No. **1003** Registrar's No. **12351**
 District No. **318** FILED JAN 11 1962

STATE FILE NUMBER

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 8 days	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3225 N. Florissant Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CLEM BOCKERSTETTE			4. DATE OF DEATH Month December Day 29 Year 1961		
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 11/11/1872	9. AGE (last birthday) 89 years	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) custodian		10b. KIND OF BUSINESS OR INDUSTRY Screw Industry	11. BIRTHPLACE (City and state or country) Cincinnati, Ohio		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Henry Bockerstette		13b. MOTHER'S MAIDEN NAME Mary Binker		14. NAME OF HUSBAND OR WIFE Maude Bockerstette	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			17. INFORMANT Address Tony Bockerstette - 2132 E. Alice		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) 4200F DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) compression Fx lumbar spine <i>compression Fx. lumbar spine</i>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Rt. fall.			
20c. TIME OF INJURY Hour 20 p.m. Month, Day, Year 12-21-1961	Fell at Little Sisters of Poor, 3225 N. Florissant				
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.) Little Sisters of Poor St. Louis, Missouri	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 12-21-1961 to 12-29-1961 and last saw him alive on 12-29-1961 . Death occurred at 10 P m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Kenneth E. Hoffman M.D.</i> (Degree or title)			22b. ADDRESS <i>Northland Med Bldg.</i>		22c. DATE SIGNED 12-30/61
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Jan 2, 1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis Missouri	(State)
24. FUNERAL DIRECTOR BUCHHOLZ MORTUARY - 5967 W. Florissant Ave		25. DATE RECD. BY LOCAL REG. JAN 2 1962		26. REGISTRAR'S SIGNATURE <i>Loed Smith M.D.</i>	

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 Raeph L. Zinder

Licensed Embalmer No. 4275

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.