

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009026  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 349

FILED FEB 23 1962

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis,</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis,</b>            |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Valley Park,</b>   |   | Length of stay in 1b <b>YRS.</b>   | c. CITY OR TOWN <b>Valley Park,</b>  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Valley Park Nursing Home, Inc.</b>   |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) <b>Valley Park Nursing Home, Inc.,</b>   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Julius</b> Middle <b>J.</b> Last <b>Bockius,</b>  |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>26,</b> Year <b>1962</b>   |  |
| 5. SEX <b>Male.</b>   | 6. COLOR OR RACE <b>White,</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>9/14/1876</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jeweler - Retired 25 Yrs.</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (last birthday) <b>85</b>   |
| 11a. FATHER'S NAME <b>J.J. Bockius</b>  |   | 11b. MOTHER'S MAIDEN NAME <b>Unknown</b>   | 11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri,</b>   |
| 12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Spanish-American</b>   |   | 12b. SOCIAL SECURITY NO. <b>None</b>   | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>  |
| 13a. FATHER'S NAME <b>J.J. Bockius</b>  |   | 13b. MOTHER'S MAIDEN NAME <b>Unknown</b>   | 14. NAME OF HUSBAND OR WIFE <b>unknown</b>   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Spanish-American</b>  |   | 16. SOCIAL SECURITY NO. <b>None</b>  | 17. INFORMANT Address <b>Mrs. Josephine Bockius, 4464 Delor St.,</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Atherosclerosis</b>   |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>80 years</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus</b>  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><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 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.  | 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 <b>Aug. 9, 1958</b> to <b>Jan. 26, 1962</b> and last saw <sup>her</sup> him alive on <b>Jan. 25, 1962</b><br>Death occurred at <b>1:45 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |  |
| 22a. SIGNATURE <b>Robert D. Sanders, M.D.</b> (Degree or title)   |   | 22b. ADDRESS <b>1502 Cass Av.</b>  | 22c. DATE SIGNED <b>1-27-62</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal.</b>   | 23b. DATE <b>1/29/62</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery, St. Louis, Missouri,</b>  | 23d. LOCATION (City, town, or county) (State)  |
| 24. FUNERAL DIRECTOR <b>Gebken-Benz Mortuary,</b> ADDRESS <b>2842 Meramec St. St. Louis, 18, Mo.</b>  |   | 25. DATE RECD. BY LOCAL REG. <b>1-27-62</b>  | 26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>   |

USE BLACK INK OR TYPEWRITER RIBBON

**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 MB Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Joe B. Benz

Licensed Embalmer No. 4249  
2842 Meramec St.,  
P. O. Address St. Louis, 18, 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.