# MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-012690
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3387

FILED APR 6 1962

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 19 Days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Jewish Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: Pine Lawn
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3719 Pine Grove
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First CLARA Middle Last GOCKEL
4. DATE OF DEATH: Month MARCH Day 30 Year 1962
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8-26-74
9. AGE (last birthday): 87
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: 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): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U. S.
13a. FATHER'S NAME: Nicholas Leonard
13b. MOTHER'S MAIDEN NAME: Martha Ratineau
14. NAME OF HUSBAND OR WIFE: John J. Gockel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: None
17. INFORMANT: William Gockel Address: Pine Lawn, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident
DUE TO (b): Cerebral arteriosclerosis
DUE TO (c): 331X
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: one week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 3-11-62, to 3-30-62 and last saw her/him alive on 3-30-62.
Death occurred at 12 10 AM. m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Oliver J. Biderman MD
22b. ADDRESS: 216 S. Kingshighway
22c. DATE SIGNED: 3-30-62
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4-2-62
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.
24. FUNERAL DIRECTOR ADDRESS: White-Millen Mortuary, Ferguson, Mo.
25. DATE RECD. BY LOCAL REG.: MAR 30 1962
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

**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 R. H. Lahrmann

Licensed Embalmer No. 3295

P. O. Address Berkeley, Calif.

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.