

SEP 14 1939

791  
1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County City of St Louis  
(b) City or town St Louis  
(c) Name of hospital or institution: St Anthonys Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 Days  
In this community Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Aloysius H. Bockerstette

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 492-10-5601

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Prim Hartman Bockerstette 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased June 12 1908  
(Month) (Day) (Year)

8. AGE: Years 31 Months 2 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St Louis Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Machinest

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Clem Bockerstette  
13. Birthplace Cincinnati Ohio (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Elizabeth Mennevever  
15. Birthplace Old Monroe Missouri (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elizabeth Bockerstette

(b) Address 4607 Labadie Ave

17. (a) Calvary (b) Date thereof 8/24/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stroot - Carroll

(b) Address 4600 Natural Bridge Ave

19. (a) AUG 22 1939 (b) Job Budick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis (If outside city or town limits, write "RURAL") 10  
(d) Street No. 4607 Labadie Ave (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21st  
year 1939 hour 7 minute 57a M.

21. I hereby certify that I attended the deceased from 8-4-39, 19\_\_\_\_, to 8-21-39, 19\_\_\_\_; that I last saw him alive on 8-20-39, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Empyema Duration 3 weeks

Due to lung abscess caused

Due to by streptococcus

Other conditions (Include pregnancy within 5 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. C. ... (Date, or other) \_\_\_\_\_  
Address 2607 S. Grand Bl Date signed 8-21-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Frank H. Short*

Licensed Embalmer No. 2265

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**