S. No. 2
1—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 20 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35173

Registration District No. 234 Primary Registration District No. 4386 Registrar's No.

1. PLACE OF DEATH:
(a) County: Oregon
(b) City or town: Thayer
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community: 14 months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Oregon 75
(c) City or town: Thayer
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Malinda Bockhorst
3. (b) If veteran, name war: --
3. (c) Social Security No.: --
4. Sex: Female /
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed 2
6. (b) Name of husband or wife: Charles M. Bockhorst
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Dec. (Month) 13 (Day) 1875 (Year)

8. AGE: Years 71 Months 9 Days 4 If less than one day hr. min.

9. Birthplace: Wright City (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Domestic
11. Industry or business:
FATHER
12. Name: William Lohman
13. Birthplace: Germany 4 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: /
15. Birthplace: Germany 4 (City, town, or county) (State or foreign country)
16. (a) Informant: Don Bockhorst
(b) Address: Thayer, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/19/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Wright City, Mo.
18. (a) Signature of funeral director: Carter Funeral Home
(b) Address: Thayer, Mo.
19. (a) 10-2-47 (Date received local registrar) (b) Edith Grass (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17 year 1947 hour 8 minute 35 A. M.
21. I hereby certify that I attended the deceased from Jan. 1, 1947 to Sept. 17, 1947 that I last saw her alive on Sept. 16, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Heart Disease Arteriosclerosis — Duration
Due to: Arteritis
Due to: Senility
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: N/A
Of autopsy:

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: C. W. Cooper (M. D. or other) M.D.
Address: Thayer, Mo. Date signed: 9-19-1947

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Cooper

RECEIVED
District Health Officer No. 5
District File Number 1047567
Date Filed 10-17-47

NOV 10 1947

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 .....

Licensed Embalmer No. .....

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, fact should be so stated above.