

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20221

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5394

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>5yrs</u>		e. STREET ADDRESS (If rural, give location) <u>5900 Arendes Dr.</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Incarinate Word Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ruth</u> b. (Middle) <u>Bokern</u> c. (Last) <u>Bokern</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 15 1954</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 8 1915</u>	9. AGE (In years last birthday) <u>38</u>	IF UNDER 1 YEAR Months Days	IF UNDER 1 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Mt. Olive Illinois</u>		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <u>August Fritzsche</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Warning</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph Bokern</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Joseph Bokern 5900 Arendes Dr.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized Carcinomatosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Primary bilateral</u> DUE TO (c) <u>Carcinoma of ovaries</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>175x</u>	

22. I hereby certify that I attended the deceased from 5-4, 1954, to 6-15, 1954, that I last saw the deceased alive on 6-15, 1954, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>P.B. Cappel MD</u> (Degree or title)		23b. ADDRESS <u>3284 Franklin Ave</u>		23c. DATE SIGNED <u>6-16-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>June 19 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Luth. Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Mt. Olive, Ill.</u>	

DATE REC'D BY LOCAL REG. <u>JUN 16 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Beiderwieden F. H. Inc. 1936 St. Louis Ave</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Licensed Embalmer No. 452

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.