

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002746

STATE FILE NUMBER

318

1003

Registrar's No. 335

JAN 28 1959

Registration District No.

Primary Registration District No.

Registrar's No.

335

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>1</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>ST. Louis</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Incarmate Word Hosp.</u> | | Length of stay in 1b | 21 st STREET ADDRESS <u>3614 Neosho</u> |
| | | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First <u>Flores</u> Middle <u>Bockius</u> Last <u>Bockius</u> | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>8</u> Year <u>1959</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 15, 1930</u> | 9. AGE (In years last birthday) <u>78</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | 11. BIRTHPLACE (City and state or country) <u>Great Bend Kansas</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
| 13. FATHER'S NAME <u>Phillip Westphal</u> | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>500-18-33938</u> | 17. INFORMANT <u>William F. Bockius</u> Address <u>3628² Bates ST.</u> | | |

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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | |
| DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Ch. Arthritis</u> <u>260X</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |

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| 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 <u>8:25</u> a. m. <u>p. m.</u> Month, Day, Year | |

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|---|--|---|--------|------------------------------------|
| 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.) <u>11/25/58</u> | 20f. CITY, TOWN, OR LOCATION <u>1/8/59</u> | COUNTY | STATE |
| 21. I attended the deceased from <u>11/25/58</u> to <u>1/8/59</u> and last saw her <u>alive</u> on <u>1/8/59</u> Death occurred at <u>8:25 p. m.</u> on the date stated above; and to the best of my knowledge, from the cause stated. | | | | |
| 22a. SIGNATURE <u>Ralph Bergman</u> (Degree or title) | | 22b. ADDRESS <u>370 38. Grand</u> | | 22c. DATE SIGNED <u>1/10/59</u> |

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|---|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE <u>Jan. 12, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u> | 23d. LOCATION (City, town, or county) (State) <u>ST. Louis, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Will Des. L. & U. G.</u> ADDRESS <u>2929 S. Jefferson</u> | 25. DATE RECD. BY LOCAL REG. <u>JAN 12 '59</u> | 26. REGISTRAR'S SIGNATURE <u>Carl Smith mo</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

144
153
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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *VE Morris*.....

Licensed Embalmer No. *3*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.