

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

7731

1. PLACE OF DEATH

County Buchanan Registration District No. 85
Township _____ Primary Registration District No. 1001
City St. Joseph (No. State Hospital #2) _____ St. _____ (Ward)

File No. _____
Registered No. 273

2. FULL NAME

Henry Hoehn
(a) Residence. No. State Hospital #2 St. _____ Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred - yrs. - mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|----------------------------------|--|
| 3. SEX <u>Male</u> | 4. COLOR OR RACE <u>white</u> | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____ | | |
| 6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 11, 1851</u> | | |
| 7. AGE | YEARS <u>78</u> | MONTHS <u>9</u> |
| | DAYS <u>23</u> | IF LESS than 1 day, _____ hrs. or _____ min. |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Printer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Darmstadt
(STATE OR COUNTRY) Germany

| | |
|---------|---|
| PARENTS | 10. NAME OF FATHER <u>Peter Hoehn</u> |
| | 11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Darmstadt</u> (STATE OR COUNTRY) <u>Germany</u> |
| | 12. MAIDEN NAME OF MOTHER <u>Mary Redlein</u> |
| | 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Darmstadt</u> (STATE OR COUNTRY) <u>Germany</u> |

14. INFORMANT W. P. Hoehn
(Address) 714 So. 18th St. St. Joseph, Mo

15. FILED MAR 5 1930
John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 4 1930
17. I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1930, to March 4, 1930, that I last saw him alive on March 4, 1930, and that death occurred, on the date stated above, at 3:50 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral arteriosclerosis
97 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 716 (duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) J. P. [Signature], M. D.
3/4, 1930 (address) State Hosp #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Olivet DATE OF BURIAL March 6, 1930
20. UNDERTAKER Eleman Funeral Home ADDRESS 946 Paulhan

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

APR 29 1930

