

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.

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

36231
Do not use this space.

NOV 15 1937

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1008**
 (c) City **St. Louis** (d) Street No. **DePaul Hospital** Registered No. **9808** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. **1/0** How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

JOSEPH A. HEPP,
 (a) Residence, No. **4473 Clarence Avenue** St. **9**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Marie Hepp. (Veach)**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Nov. 13, 1889**
 7. AGE YEARS **47** MONTHS **11** DAYS **8** If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Meter Reader**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Union Electric**
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo**

FATHER 13. NAME **Joseph Hepp**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo**

MOTHER 15. MAIDEN NAME **Katherine Kessler**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo**

17. INFORMANT (ADDRESS) **Mrs Marie Hepp 4473 Clarence Ave**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **Oct. 25, 1937**

19. FUNERAL DIRECTOR (ADDRESS) **Math. Hermann & Son 2161 East Fair Avenue**

20. FILED **OCT 22 1937** **J. Bredeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct. 21, 1937**

22. I HEREBY CERTIFY, That I attended deceased from **October 18, 1937** to **Oct 21, 1937**.
 I last saw him alive on **Oct 20, 1937** Death is said to have occurred on the date stated above, at **1:21 a. m.**
 The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
Influenza
 Date of onset **93c**

Other contributory causes of importance:
 Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify **Lloyd L Heid** M. D.
 (Signed) **Lloyd L Heid** (Address) **306 Lindell in Bldg**

STATEMENT BY LICENSED EMBALMER:

I, William G. Buchholz, Licensed Embalmer No. 2110

hereby certify that the body recorded on the reverse side of this certificate was embalmed by William G.

Buchholz, L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed William G. Buchholz

Licensed Embalmer No. 2110

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.)