

REC'D JUL 19 1938

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

22622

Do not use this space.

## 1. PLACE OF DEATH

(a) County PerryRegistration District No. 660

(b) Township

Primary Registration District No. 4396

Registered No. \_\_\_\_\_

(c) City Perryville Mo.

(d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Elizabeth M. Hoehn500(a) Residence, No. \_\_\_\_\_ St. 

(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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR

DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF

(OR) WIFE OF

John M. Hoehn

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Sept. 2 1862

7. AGE

YEARS

75

MONTHS

10

DAYS

5If LESS than 1  
day, ..... hrs.  
or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of  
work done, as sawyer, bookkeeper, etc.9. Industry or business in which work  
was done, as saw mill, bank, etc.10. Date deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation12. BIRTHPLACE (CITY OR TOWN)  
(STATE OR COUNTRY)Perry Co. Mo.

13. NAME

John P. Muench14. BIRTHPLACE (CITY OR TOWN)  
(STATE OR COUNTRY)Germany

15. MAIDEN NAME

Rosena Meyer16. BIRTHPLACE (CITY OR TOWN)  
(STATE OR COUNTRY)Germany17. INFORMANT  
(ADDRESS)Mrs. Fred Bergman  
Perryville Mo.

18. BURIAL, CREMATION, OR REMOVAL

Perryville Mo. DATE July 9 193819. FUNERAL DIRECTOR (NAME)  
(ADDRESS)Young & Sons  
Perryville Mo.

20. FILED

July 9 1938 Jos J. Zollner  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

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

July 7 1938

22. I HEREBY CERTIFY That I attended deceased from

March 15 1935 to July 7 1938I last saw her alive on July 6 1938 Death is saidto have occurred on the date stated above, at 2:00 A. M.

The principal cause of death and related causes of importance were as follows:

Cerebral Apoplexy

Date of onset

5 days

Other contributory causes of importance:

Hypertension  
Essential Arteriosclerosis  
Chronic Myocarditis  
Chronic NephritisSyphilis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 Cerebral Artery \_\_\_\_\_, M. D.

(Signed) \_\_\_\_\_

595 (Address) Perryville Mo.

**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

*Walter Young*

Licensed Embalmer No. ....

*4027*

P. O. Address

*Perryville*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

(a) County Rever Registration District No. 660  
(b) Township \_\_\_\_\_ Primary Registration District No. 4396 Registered No. \_\_\_\_\_  
(c) City Ferryville (d) Street No. \_\_\_\_\_ 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. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Elizabeth M. Hoehn  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 7, 1938

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 72 10 5

The principal cause of death and related causes of importance were as follows:

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

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:

FATHER 13. NAME

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT (ADDRESS)

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

Manner of injury \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

Nature of injury \_\_\_\_\_

20. FILED Syracuse 1938 Josef Zeln Local Registrar.

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify

(Signed) Oscar A. Carson, M. D.

(Address) Ferryville Mo

SUPPLEMENTARY

REQUIREMENT: EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

