

REC'D FEB 10 1939

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

357

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) or City **St. Louis** (d) Street No. **Homer Phillips Hospital** 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 **29** yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. **357**2. PRINT FULL NAME **260 Frank Höcker**

(a) Residence, No. **3920 Fairfax** St. **11** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **C** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **unknown**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 1, 1869**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 -- 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **nil**
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

12. BIRTHPLACE (CITY OR TOWN) **Missouri** (STATE OR COUNTRY)13. NAME **unknown**14. BIRTHPLACE (CITY OR TOWN) **unknown** (STATE OR COUNTRY)15. MAIDEN NAME **unknown**16. BIRTHPLACE (CITY OR TOWN) **unknown** (STATE OR COUNTRY)17. INFORMANT **Evelyn Hilliard** (ADDRESS) **2601 N Whittier**18. BURIAL, CREMATION OR REMOVAL PLACE **Washington** DATE **1-14** 193919. FUNERAL DIRECTOR (NAME) **Manuel** (ADDRESS) **4059 Tanager**20. FILED **JAN 11 1939** **J. B. Beckwith** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 7** 19**39**22. I HEREBY CERTIFY, That I attended deceased from **Jan. 4**, 19**39**, to **Jan. 7**, 19**39**I last saw him alive on **Jan. 7**, 19**39**. Death is said to have occurred on the date stated above, at **12:25a.m.**

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

Cerebral hemorrhageDate of onset **1/4/39**

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? **clinical** 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? **1**
If so, specify **Herbert Grossman**, M. D.
(Signed) **2601 N Whittier**
(Address)

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

William C. McDowell

Registered Apprentice No.

working under my personal supervision.

Signed

William C. McDowell

Licensed Embalmer No.

2114

P. O. Address

3506 Franklin

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