

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33865
Registrar's No. 8403

NOV 13 1939 791
Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH: 1005
(a) County _____
(b) City or town St. Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town Warrenton WR
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME August E. Hoelscher 426
3. (b) If veteran, name war No 3. (c) Social Security No. No
4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anna 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased March 9th 1872
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct 1 day 1 year 1939 hour _____ minute 30 a.m.
21. I hereby certify that I attended the deceased from Sept 30 1939, to Oct 1 1939; that I last saw him alive on Oct 1 1939; and that death occurred on the date and hour stated above.

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>67</u> | <u>6</u> | <u>22</u> | hr. _____ min. |

Immediate cause of death Diphtheria Septicemia Duration 10 Days
Due to _____
Due to _____

9. Birthplace Holstein Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Letter Carrier
11. Industry or business _____
12. Name Ernest Hoelscher
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Minnie Kauset
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

Other conditions Metabolic Insufficiency
(Include pregnancy within 3 months of death)
Major findings: Of operations None
Of autopsy No
PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Anna Hoelscher
(b) Address Warrenton Missouri
17. (a) Burial (b) Date thereof 10 3 39
(Burial, cremated, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Warrenton Missouri
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd
19. (a) OCT 2 1939 (b) _____
(Date received local registration) (Signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature A. H. Hoppe (M. D. optional) _____
Address 4700 Washington Blvd Date signed 10/1/39

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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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 H. Kasper
.....
Licensed Embalmer No. *186*

P. O. Address.....

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.