

AUG 25 1940
Registration District No. **791**

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **4228 WESTMINSTER**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community **7 1/2** years, months or days

3. (a) PRINT FULL NAME **ROHANI VAN HOEFEN 515**

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **ERZEBINDA VAN HOEFEN** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **MARCH 31 1887**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	52	3	15	hr. _____ min. _____

9. Birthplace **ST. LOUIS**
(City, town, or county) (State or foreign country)

10. Usual occupation **ATTORNEY OF LAW**

11. Industry or business _____

MOTHER FATHER { 12. Name **SAMUEL VAN HOEFEN**

13. Birthplace **BORNEO**
(City, town, or county) (State or foreign country)

14. Maiden name **REBECCA GAST**

15. Birthplace **ST. LOUIS**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Erzgebinda Van Hoefen**

(b) Address **4228 Westminster**

17. (a) **CREMATION** (b) Date thereof **JULY 16 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **VALHALLA CREMATORY**

18. (a) Signature of funeral director **DIETRICH FUNERAL HOME**

(b) Address **8319 HALL'S FERRY RD.**

19. (a) **JUL 18 1940** (b) **J. F. Brebeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County _____
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL") **19**
(d) Street No. **4228 WESTMINSTER**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **15**
year **1940** hour **4:00** minute **0** P. M.

21. I hereby certify that I attended the deceased from **4:25-40**
_____, 19____, to **7-15-40**, 19____;

that I last saw him alive on **7-15-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral aneurysm of occipital artery.

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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?

(Specify type of place) (e) Means of injury _____

23. Signature **Hallerin** (M. D. or other) **M.D.**

Address **5074 N. Union** Date signed **7-15-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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.....

Arthur R. Diederich

Licensed Embalmer No. *3556*

P. O. Address. *St. Louis City*

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.