

Registration District No. **791**

Primary Registration District 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:
Christian Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 40 days
(Specify whether _____)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State, Missouri (b) County _____
 (c) City or town St. Louis **9**
(If outside city or town limit, write "RURAL")
 (d) Street No. 4566a Fair Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME EMMA HOEHN
 (b) If veteran, name war None
 (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Emil J. Hoehn 6. (c) Age of husband or wife if alive 68 years
 7. Birth date of deceased March 26, 1870
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
 { 12. Name John H. Diel
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Anna Bernicus
 15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Emil J. Hoehn
 (b) Address 4566a Fair Ave.

17. (a) Burial (b) Date thereof 10/3/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director [Signature]

(b) Address 2117 E. Grand Blvd.

19. (a) OCT 1 1940
(Date received local registration)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 30
 year 1940 hour 6 minute 10 P. M.

21. I hereby certify that I attended the deceased from Sept 30, 1940, to 9-30, 1940
 that I last saw him/her alive on 9-30, 1940
 and that death occurred on the date and hour stated above.
 Immediate cause of death Ch. Hypertension Duration _____

Due to 930
 Due to _____

Other conditions Hemiplegia left - ?
(Include pregnancy within 3 months of death)

Major findings: Caused by cerebral hemorrhage 6 mos ago
 Of operations _____
 Of autopsy none
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 [Signature] (M. D. or other) MD
 Address 5738 W. Flourent Date signed 9-30-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Al Crowe
5738 N. Flamingo
Et 6857

12-1

Res 5403 Clapton
G0 6103

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

Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address 2117 E. Grand

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.