

V. S. No. 2  
50M-5-42  
Rev. 5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED FEB 10 1943

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Permit 83437/0  
State File No. \_\_\_\_\_  
Registrar's No. 118

Registration District No. 108

Primary Registration District No. 200

Registrar's No. 118

1. PLACE OF DEATH:  
(a) County ST. LOUIS  
(b) City or town KOEHL  
(c) Name of hospital or institution: ROBERT KOEN 1008 P. O.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 yrs - 9 mo - 4 d  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County -  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL.")  
(d) Street No. 725 EUCLID  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM HINES  
(b) If veteran, name war No  
(c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 1 day 15  
year 1943 hour 4 minute - A.M.

4. Sex MALE  
5. Color or race WHITE  
6. (a) Single, widowed, married, divorced, widower  
6. (b) Name of husband or wife MITTIE HINES  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 11 - 28 - 1878  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4 - 6 - 1932 to 1 - 15 - 1943  
that I last saw him alive on 1 - 14 - 1943  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	66	7	17	hr. min.

Immediate cause of death  
Pulmonary Tuberculosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace OHIO  
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy Preliminary Tuberculosis

10. Usual occupation none

11. Industry or business \_\_\_\_\_  
12. Name WILLIAM HINES  
13. Birthplace SCOTLAND  
(City, town, or county) (State or foreign country)  
14. Maiden name SARAH CLIFFORD  
15. Birthplace IRELAND  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant PATIENT Charles Bochen  
(b) Address 3909 - Shenandoah

17. (a) Place of burial or cremation St. Matthews Cemetery  
(b) Date of burial or cremation Jan 16 - 43  
(Month) (Day) (Year)

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director J. J. McLaughlin  
(b) Address 1109 E. 9th St.  
19. (a) JAN 19 1943 (Date received local registration)  
(b) J. J. McLaughlin M.D. (Registrar's signature)

23. Signature Paul S. Kewenow (M. D. or other)  
Address 1008 P. O. Koehl, MO Date signed 1/27/43

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

196  
000

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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 Juddie A. Ziegenhain  
Licensed Embalmer No. 2270  
P. O. Address: 6409 Brown

**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, fact should be so stated above.

STATE OF ILLINOIS