S. No. 2
M—5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED MAR 11 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

7429

State File No. 7429

Registration District No. 306 Primary Registration District No. 6048 Registrar's No. 190

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

1. PLACE OF DEATH:
(a) County: St. Charles
(b) City or town: O'Fallon Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Precious Blood Convent 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Charles
(c) City or town: O'Fallon
(If outside city or town limits, write "RURAL")
(d) Street No.: Precious Blood Convent
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Rev. George Hoehn
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: June (Month) 11 (Day) 1856 (Year)
8. AGE: Years 86 Months 7 Days 28 If less than one day ..... hr. ..... min.
9. Birthplace: Heppenheim (City, town, or county) Germany 4 (State or foreign country)
10. Usual occupation: Religious
11. Industry or business: .....
FATHER
12. Name: William Hoehn
13. Birthplace: Germany 4 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Anna Meinberg
15. Birthplace: Germany 4 (City, town, or county) (State or foreign country)
16. (a) Informant: Rev. Hellriegel
(b) Address: St. Louis, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 12-1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Convent Cem. O'Fallon
18. (a) Signature of funeral director: H. C. Dallmeyer & Sons Co.
(b) Address: 801 N. Second, St. Charles, Mo.
19. (a) Feb 18-43 (Date received local registrar) (b) E. A. Keirsley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9 year 1943 hour 8 minute A M.
21. I hereby certify that I attended the deceased from Jan 1. 1940 to Feb. 9 1943 that I last saw him alive on Feb 8 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchio Pneumonia	4 days
Due to: Myocarditis	5 yrs
Due to: Hypertrophic prostate	5 yrs.
Other conditions (Include pregnancy within 3 months of death): Fractured femur	6 mo.

Major findings:
Of operations: .....
Of autopsy: .....

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): 092
(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)
While at work? (e) Means of injury: .....
23. Signature: Nicholas J. Hoenel (M. D. or other)
Address: O'Fallon, Mo. Date signed 2/11/43

(Licensed Embalmer's Statement on Reverse Side)

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 John E Dallmeyer

Licensed Embalmer No. 2951

P. O. Address St Charles Mo

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.

. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7429

Registration District No. 306 Primary Registration District No. 6048 Registrar's No. 190

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

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

3. (a) PRINT FULL NAME Rev George Hoehn
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 11 (Day) 1857 (Year)
8. AGE: Years 86 Months 7 Days 28 If less than one day hr. min.
9. Birthplace (City, town, or county) Germany (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 9 year 1943 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19, that I last saw him alive on 19, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	4 days
Due to myocarditis	5 yrs
Due to Hypertrophic prostatic	5 yrs
Other conditions Fractured femur Dec. 11, 1942	6 mo.

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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? Home (Specify type of place)
While at work? No (e) Means of injury Fall
23. Signature Nicholas J. Hoenich M.D. (M. D. or Coroner)
Address O'Fallon, Mo Date signed 3/31/43

SUPPLEMENTARY