

S. No. 2
-11-10-39
5-17-39
P1 X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

32541/

State File No. _____

Registrar's No. 2089

Registration District No. 277

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town WELLSTON MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1542 VALLE AVE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

8. (a) PRINT FULL NAME ARTHUR W. HOEFS

8. (b) If veteran, name war NO
8. (c) Social Security No. 497-16-7994

4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife VIDA HOEFS
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased NOVEMBER 25 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 10 16 hr. _____ min.

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

10. Usual occupation CARPENTER

11. Industry or business _____

MOTHER FATHER {
12. Name AUGUST HOEFS
13. Birthplace GERMANY 4
(City, town, or county) (State or foreign country)
14. Maiden name MARGARET SHEATS
15. Birthplace GERMANY 4
(City, town, or county) (State or foreign country)

16. (a) Informant VIDA HOEFS (WIFE)
(b) Address 1542 VALLE AVE
17. (a) CREMATION (b) Date thereof SEPT 17, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation VALHALLA

18. (a) Signature of funeral director MARK TILSON
(b) Address 6100 W. FLORISSANT

19. (a) SEP 18 1943 (b) E. J. Mc Gowan
(Date received local registrar) (Registrar's signature) 25.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 7
(c) City or town St. Louis Wellston
(If outside city or town limits, write "RURAL")
(d) Street No. 1542 Valle Ave,
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept, day 16th
year 1943 hour 7: minute 45 M.

21. I hereby certify that I attended the deceased from 6/30/43
_____, 19____, to 9/16/43, 19____;
that I last saw him alive on 9/16/43, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chr-Diabetes mellitus Duration
Chro- Int-Nephritis ?
Chro- Arterio-sclerosis ?
Due to Myo- Carditis ?
Sec: Pancreatitis -Chro-Dermatitis/ 3-MO
Due to Generalized- anasarca 3-MO
Block- heart 6-MO
Other conditions Myo-cardial-congestion 3-MO
(Include pregnancy within 9 months of death)
Pul- Oedema 3-MO

Major findings:
Of operations _____
Of autopsy No. 1

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence As stated
(c) Where did injury occur? Illness
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? AS STATED (Specify type of place) Means of injury
23. Signature D. J. Jennings (M. D. or other)
Address 3718 Jennings, P.A. Date signed _____

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

9600

707

(Licensed Embalmer's Statement on Reverse Side)

SEP 30 1954

AUG 25 1954

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 Mark T. Terson

Licensed Embalmer No. 4174

P. O. Address 6100 W. Florissant

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.