

S. No. 2
JM-5-43
y. 5-17-39
P. 1 X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5257
Registrar's No. 1681

FILED MAR 1 1944 18

Registration District No. _____ Primary Registration District No. 1003

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

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:
Jewish Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
 years, months or days

3. (a) PRINT FULL NAME Julius C. Hoester Sr.

3. (b) If veteran, name war _____ No. _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Mary Alice Hoester 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Feb 17 1869
(Month) (Day) (Year)

8. AGE: Years 75 Months X Days X If less than one day _____ hr. _____ min.

9. Birthplace St. Charles Co. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Pharmist

11. Industry or business _____

MOTHER FATHER { 12. Name Anton Hoester

13. Birthplace St. Charles Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Tappe

15. Birthplace St. Charles Co Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. F. Impey

(b) Address 424 N. Clay Ave Kirkwood, Mo

17. (a) Burial (b) Date thereof 2-20-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cem.

18. (a) Signature of funeral director Louis H. Bopp Inc.
 (b) Address Kirkwood, Mo.

19. (a) FEB 21 1944 (b) J. F. Bradech
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis ⁹⁶

(c) City or town Kirkwood
(If outside city or town limits, write "RURAL") ^{3 N.P.}

(d) Street No. 424 N. Clay Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17 year 1944 hour 7 minute 34 P. M.

21. I hereby certify that I attended the deceased from Feb 15 1944 to Feb 17 1944
 that I last saw him alive on Feb 17 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Carcinoma of Recto Sigmoid 70
 Duration about 1

Due to _____

Due to _____
Mesenteric thrombosis

Other conditions Mesenteric thrombosis
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Carcinoma of Recto Sigmoid
 Of operations _____

Of autopsy Mesenteric thrombosis
same

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 o

23. Signature D. L. Keyes MD (M. D. or other) _____
 Address 4952 Maryland Date signed Feb 17

1891

1891

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.....

Felix Hurand

Licensed Embalmer No.....

3034

P. O. Address.....

Kirkwood 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.