

1. PLACE OF DEATH:  
 (a) County St Charles  
 (b) City or town Defiance  
(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) 1  
 (d) Length of stay: In hospital or institution None (Specify whether)  
 In this community Life  
years, months or days

3. (a) PRINT FULL NAME Theodore Hohl  
 3. (b) If veteran, name war World War Nol  
 3. (c) Social Security No. Cant find

4. Sex M | 5. Color or race W  
 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 Dont Know  
(Month) (Day) (Year)

8. AGE: Years About 53 Months Dont know Days hr. If less than one day min.

9. Birthplace St Charles Co  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Labor

MOTHER FATHER  
 11. Industry or business  
 12. Name John Hohl  
 13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
 14. Maiden name Dont Know  
 15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Jane Messing  
 (b) Address St Charles, Mo  
 17. (a) Burial (b) Date thereof Nov 22-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Funeral Cemetery  
 18. (a) Signature of funeral director [Signature]  
 (b) Address Wentzville, Mo  
 19. (a) Nov 29/44 (b) [Signature]  
(Date received local registrar) (Registrar's Signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 21st  
 year 1944, hour 1 minute A.M.  
 21. I hereby certify that I attended the deceased from Coroners Inquest  
 that I last saw h alive on 19  
 and that death occurred on the date and hour stated above.

Immediate cause of death Mutilation of entire Body.  
 Due to 169/8  
 Due to 30  
 Other conditions 169/8  
(Include pregnancy within 3 months of death)

Duration

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) accident  
 (b) Date of occurrence Nov 21st 1944 1 Am  
 (c) Where did injury occur? St Charles Co. Mo.  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
MKT. R.R. Highway Hy 94 1/2 Fullerton  
(Specify type of place)  
 (e) While at work? No (e) Means of injury Struck by train  
 23. Signature A.P. Erish Schick (M. D. or other)  
 Address St Charles Mo Date signed 11/21/44

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

200

92

683

DEC 21 1944

**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.....

Licensed Embalmer No. 2461

P. O. Address Wentzville, 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.

Handwritten marks and scribbles at the bottom right of the page.