

V. S. No. 2  
00M-5-43  
Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39264**  
**11069**  
Registrar's No. \_\_\_\_\_

**FILED** DEC 28 1945  
318

Registration District No. \_\_\_\_\_ Primary Registration District No. **100**

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

1. PLACE OF DEATH:  
(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital-Max C. Starkloff  
(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 CAROLINE HEMKER  
3. (b) If veteran, name war Nil 3. (c) Social Security No. None

4. Sex Female 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 January 11 1941  
(Month) (Day) (Year)

8. AGE: Years 4 Months 11 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name Bernard J. Hemker

13. Birthplace Germantown Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Caroline Ortmann

15. Birthplace Carlyle Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Bernard J. Hemker  
(b) Address Germantown, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-18-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Germantown, Ill.

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.

19. (a) DEC 10 1945 (Date received local registrar) J. F. Brewer (Registrar's signature)

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 17th  
year 1945 hour 10:10 minute A M.  
21. I hereby certify that I attended the deceased from 12/9/45  
12/17/45, 19\_\_\_\_, to 12/17/45, 19\_\_\_\_;  
that I last saw her alive on 12/17/45, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Poliomyelitis  
Due to \_\_\_\_\_  
Due to 36  
Other conditions 36  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)  
(c) Means of injury \_\_\_\_\_  
23. Signature D. Leggett (M. 12/27/45)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

69011

STATEMENT BY LICENSED EMBALMER

69011

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 *W W Wilkinson*

Licensed Embalmer No. *3575*

P. O. Address.....

**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.**