

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26352**

FILED AUG 4 1947
Registration District No.

Primary Registration District No. **6076**

Registrar's No. **1645**

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

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Lemay**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **286 Lemay Ferry Road**
(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 **John Hoefler**

3. (b) If veteran, name war *********

3. (c) Social Security No. _____

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 **Unknown**
(Month) (Day) (Year)

8. AGE: Years **About 63** Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

12. Name **Unknown**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Nancy Summers**

(b) Address **286 Lemay Ferry Road**

17. (a) **Burial** (b) Date thereof **7-31-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews Cemetery**

18. (a) Signature of funeral director **Fiegenten Bros.**

(b) Address **6408 Gravois Ave**

19. (a) **8-2-47** (b) **Richard J. Thompson**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **Lemay**
(If outside city or town limits, write "RURAL")

(d) Street No. **286 Lemay Ferry Road**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **27th** day **July** year **1947** hour **7:30** minute **Am** M.

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

Immediate cause of death **Myocarditis**

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause of 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)
Signature **Robert J. Sharp** (M. D. or other)

Address **Health Commissioner** Date signed **7/30/47**

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..... *Homer W. Fritz*

Licensed Embalmer No. *38820*

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.