FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED APR 26 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11572

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 432

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Methodist Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 days (Specify whether
In this community: 3 days (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Buchanan
(c) City or town: St Joseph (If outside city or town limits, write "RURAL")
(d) Street No.: 407 E Highland Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: MARY-ALICE-HOENIKE
3. (b) If veteran, name war: none
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: April (Month) 8 (Day) 1948 (Year)

8. AGE: Years 0 Months 0 Days 3 If less than one day hr. min.

9. Birthplace: St Joseph (City, town, or county) Mo (State or foreign country)
10. Usual occupation: none
11. Industry or business: none
FATHER
12. Name: Robert Milton Hoenike
13. Birthplace: Fall City Nebr (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Dorothy Mae Spaulding
15. Birthplace: Dawson Nebr (City, town, or county) (State or foreign country)
16. (a) Informant: R. M. Hoenike
(b) Address: St Joseph Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 4-11-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Fall City Nebr
18. (a) Signature of funeral director: Stamey Funeral Home
(b) Address: St Joseph Mo
19. (a) 4-19-48 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature) 297

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: April day: 11th year: 1948 hour: 3 A.M. minute: M.
21. I hereby certify that I attended the deceased from: April 8 4:30 A.M., 1948 to April 11, 1948 that I last saw h alive on: April 10, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Inanition — Prematurity
Due to:
Due to:
Other conditions: none (Include pregnancy within 3 months of death)
Major findings: Of operations: ✓
Of autopsy: Not done

Duration

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: H. D. Kearby M.D. (M. D. or other) 0
Address: 317 Kerkpatrick Bldg St. Joseph, Mo Date signed: April 11 1948

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

707206

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~~ not embalmed

..... Registered Apprentice No.....

working under my personal supervision.

Signed Charles M. Harman

Licensed Embalmer No. 4487

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.