

FILED FEB 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2328

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>O'Fallon Rural</u>	
c. LENGTH OF STAY (in this place) <u>4 days</u>		d. STREET ADDRESS (If rural, give location) <u>-----</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Casper</u> b. (Middle) <u>----</u> c. (Last) <u>Hoeckelmann</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>January 15 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>Feb. 28 1869</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (State or foreign country) <u>O'Fallon Rural</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S</u>
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13a. FATHER'S NAME <u>Frederick Hoeckelmann</u>	13b. MOTHER'S MAIDEN NAME <u>Westhoff</u>	14. NAME OF HUSBAND OR WIFE <u>-----</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Albert Hoeckelmann</u> ADDRESS <u>O'Fallon Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumo pneumonia</u>		<u>1 wk.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>malnutrition</u> DUE TO (c) _____		<u>2 mos.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>491X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 1-6, 1947 to 15 Jan, 1949, that I last saw the deceased alive on 15 Jan, 1949, and that death occurred at 11:20 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Lawrence B Behan M.D.</u>	23b. ADDRESS <u>O'Fallon Mo.</u>	23c. DATE SIGNED <u>1-21-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan. 18 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Assumption</u>	24d. LOCATION (City, town, or county) (State) <u>O'Fallon Mo. Rural</u>
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DATE REC'D BY LOCAL REG. <u>1-27-49</u>	REGISTRAR'S SIGNATURE <u>Fannie Hamilton</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. K. Kelly</u> ADDRESS <u>O'Fallon Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 9,
District No. 9,
District Health Officer No. 9,
Date Filed. JAN 31 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *E. K. Keith*

Licensed Embalmer No. *874*

P. O. Address *Dallas 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.