

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

26

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4026 N. Florissant Ave		d. STREET ADDRESS (If rural, give location) 4026 N. Florissant Ave	
3. NAME OF DECEASED (Type or Print) Laura Hoener			4. DATE OF DEATH (Month) (Day) (Year) Jan. 26 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 14, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years) last birthday 60
11. BIRTHPLACE (State or foreign country) St. Louis, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Christ Kleine		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Edwin Hoener
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Edwin Hoener 4026 N. Florissant
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Endocarditis (acute dilatation) ANTECEDENT CAUSES Endocarditis of Heart. DUE TO (b) _____ DUE TO (c) _____ 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	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 27, 1948 , to Jan 27, 1949 , that I last saw the deceased alive on Jan 27, 1949 , and that death occurred at 4:15 p.m. , from the cause and on the date stated above.			
23a. SIGNATURE (Degree or title) Carl O. Ottesbach M.D.		23b. ADDRESS 1509 Bremen Ave	23c. DATE SIGNED Jan 28, 49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 29, 1949	24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, COUNTY MO.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Suedmeyer & Son's 3934 N. 20 Street		

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.

Signed _____

Novelle B. Throckmorton

Signed _____
Student Embalmer

Licensed Embalmer No. *3696*

P. O. Address *15402 N 48th*

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.