

FILED FEB 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5839

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

BIRTH NO. <u>310</u>		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>8058</u>		Registrar's No. <u>325</u>	
1. PLACE OF DEATH a. COUNTY <u>St Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u> <u>112</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Town St Charles</u>		c. LENGTH OF STAY (In this place) <u>2 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Ryral Rt # 2</u> <u>8</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Rt # 2</u> <u>1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>J</u> c. (Last) <u>Hobelmann</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>February 13 1949</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>December 9 1871</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>		11. BIRTHPLACE (State or foreign country) <u>Marthasville Mo</u> <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Ida Leporin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>Spanish American</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>William J Hobelmann Jr St Charles Mo</u>			
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 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fractured Hip (ret)</u>				INTERVAL BETWEEN ONSET AND 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) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) <u>St. Charles Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>2-2-1949</u> <u>m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>Fall</u> <u>112</u>			
22. I hereby certify that I attended the deceased from <u>Feb 2</u> , 19 <u>49</u> , to <u>Feb 13</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Feb 13</u> , 19 <u>49</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>George R. Szabik M.D. (1)</u>				23b. ADDRESS <u>St. Charles Hotel Bldg</u>		23c. DATE SIGNED <u>2-13-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 16 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St John's</u>		24d. LOCATION (City, town, or county) (State) <u>St Charles Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-16-49</u>		REGISTRAR'S SIGNATURE <u>James H. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. ...</u>		ADDRESS <u>St. Charles</u>	

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed FEB 18 1949

FEB 24 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

Arthur C. Bane

Licensed Embalmer No. *3154*

P. O. Address

A. C. Bane M.D.

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.