

FILED MAR 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7975

BIRTH NO. _____		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>3020</u>		Registrar's No. <u>43</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY Franklin.		b. CITY (If outside corporate limits, write RURAL and give town or township) Washington.		a. STATE Missouri.		b. COUNTY Franklin.	
c. LENGTH OF STAY (in this place) 8 days.		c. CITY (If outside corporate limits, write RURAL and give township) Washington.		d. STREET ADDRESS (If rural, give location) 104 E. Main St.			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital.							
3. NAME OF DECEASED (Type or Print)		a. (First) Henry		b. (Middle) H.		c. (Last) Hoemann	
4. DATE OF DEATH (Month) (Day) (Year) Mar. 8th, 1949.		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Sept. 26th, 1880.		9. AGE (In years last birthday) 68		10. MONTHS 5		11. DAYS 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Messenger.		10b. KIND OF BUSINESS OR INDUSTRY Post Office Dept.		11. BIRTHPLACE (State or foreign country) New Haven, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Herman Hoemann.		13b. MOTHER'S MAIDEN NAME Catherine Beckmann.		14. NAME OF DECEASED'S WIFE Pauline W. Hoemann.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) X		16. SOCIAL SECURITY NO. None.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS. Mrs. Henry H. Hoemann Washington, Mo.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Thrombosis		ANTECEDENT CAUSES					
		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) Arterial Sclerosis					
		DUE TO (c) Hypertrophy of Prostate					
II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or conditions causing death.		Cerebral Thrombosis				2 hrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION none				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) (Minute) 7:15 AM		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1</u> , 19 <u>49</u> , to <u>3-8</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>7</u> , 19 <u>49</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) Charles Schmidt M.D.				23b. ADDRESS Gerald MO			
23c. DATE SIGNED 3-9-49		24a. BURIAL CREMATION REMOVAL (Specify) Burial		24b. DATE Mar. 11th, 1949		24c. NAME OF CEMETERY OR CREMATORY Immanuel Lutheran Cemetery	
24d. LOCATION (City, town, or county) (State) Washington, Mo.		DATE REC'D BY LOCAL REG. Mar. 10, 1949		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hueburg & Vitt Inc. Washington, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10.48'

36
6

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed MAR 16 1949

APR 10 1961

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 _____

working under my personal supervision. _____ Student Embalmer No. _____

Signed _____
Student Embalmer

Signed *Lester A. Clark*
Licensed Embalmer No. *3251*
P. O. Address *Washington, 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.