

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10172
State File No. _____
Registrar's No. 3020

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis.</u>)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>City Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>910 Benton St.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank.</u>		c. (Last) <u>Hoelscher Sr.</u>	
b. (Middle)		4. DATE OF DEATH (Month) (Day) (Year) <u>4 1- 49.</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec. 26th 1873</u>
9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>	
11. BIRTHPLACE (State or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>Frank Hoelscher.</u>		13b. MOTHER'S MAIDEN NAME <u>unknown.</u>	
14. NAME OF HUSBAND OR WIFE <u>Clara Hoelscher.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clara Hoelscher 910 Benton St.</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		II. OTHER SIGNIFICANT CONDITIONS			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Antecedent Causes			
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Cerebral (left frontal)</u>			
		DUE TO (c) <u>hemiplegia</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (m.)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:15 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Thomas E. Doyle 3</u>		23b. ADDRESS <u>1300 Clark</u>		23c. DATE SIGNED <u>4/14/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-4-49.</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo</u>		DATE REC'D BY LOCAL REG. <u>APP</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hy. Leidner U. 2223 St. Louis Ave</u>					

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

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 *John P. Buchholz*
Licensed Embalmer No. *1674*
P. O. Address *2223 St. Louis*

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.