

FILED MAR 29 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2446  
Registrar's No. 1003

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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 <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <i>St. Louis</i>		c. LENGTH OF STAY (in this place) <i>1 2 1/2</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Louis State Hospital</i>		d. STREET ADDRESS (If rural, give location) <i>5400 Arsenal St.</i>	
3. NAME OF DECEASED (Type or Print) <b>WILLIAM</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Mar. 12, 1951</b>	
a. (First)		b. (Middle)	
c. (Last) <b>HOERST</b>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>sgl</i>	8. DATE OF BIRTH <i>7/26/10</i>
9. AGE (In years: last birthday) <i>40</i>		10. IF UNDER 1 YEAR: Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>husk</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>4</i>	
13a. FATHER'S NAME <i>Wm. Hoerst</i>		13b. MOTHER'S MAIDEN NAME <i>Louise Ziegler</i>	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <i>Hospital Records.</i>		ADDRESS	

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) <i>Lukemia</i>		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
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 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 type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>20ft. H</i>	

22. I hereby certify that I attended the deceased from *Oct. 6*, 19 *39*, to *Mar. 12*, 19 *51*, that I last saw the deceased alive on *Mar. 12*, 19 *51*, and that death occurred at *7:30a* m., from the causes and on the date stated above.

23a. SIGNATURE <i>L. Novakovich M.D.</i>		23b. ADDRESS <i>5400 Arsenal St.</i>		23c. DATE SIGNED <i>3/13/51</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>6</i>		24b. DATE OF BURIAL <i>1 5 1951</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Antoine's Park</i>	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE <i>Rowland Secondary Service Inc.</i>		ADDRESS <i>4104 Manchester Ave. St. Louis 10, Mo.</i>	
DATE REC'D BY LOCAL REG. <i>MAR 15 1951</i>		REGISTRAR'S SIGNATURE <i>J. B. Luster</i>			

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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.....

Signed.....  
Student Embalmer

Licensed Embalmer No.....  
1

P. O. Address.....

[ 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.