

FILED APR 27 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14232**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3531**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Luthern Hospital		d. STREET ADDRESS (If rural, give location) 1419 So 12th St.	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) Albert	b. (Middle) E	c. (Last) Hinze	(Month) (Day) (Year) 4 12 51
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan 3 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months Days 62
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Ernest Hinze	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Elsie Hinze
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elsie Hinze 1419 So 12th St.

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	Cerebral Embolism		
	ANTECEDENT CAUSES		
	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b)		
	Chronic Myocarditis		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS		
	Conditions contributing to the death but not related to the disease or condition causing death.		
	Bronchial Asthma		

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? H222
22. I hereby certify that I attended the deceased from 4/9 ¹⁹ 51 at 4:12 ^{PM} , 19 51 , that I last saw the deceased alive on 4/12 , 19 51 , and that death occurred at 4:30 ^{PM} from the causes and on the date stated above.		

23a. SIGNATURE W. C. Hansen MD	(Degree or title)	23b. ADDRESS 3012 Lafayette	23c. DATE SIGNED 4/14/51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-16-51	24c. NAME OF CEMETERY OR CREMATORY New Picker Cem	24d. LOCATION (City, town, or county) (State) St. Louis Mo

DATE REC'D BY LOCAL REG. APR 16 1951	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home 1926 Allen
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(Licensed Embalmer's Statement on Reverse Side)

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

Miss

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 me

working under my personal supervision.

Student Embalmer No.

Signed Alfred A. Sturman

Signed.....
Student Embalmer

Licensed Embalmer No. 9533

P. O. Address St Louis 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.