

No. 300
10.48

FILED DEC 8 - 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39152

State File No. 10672

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10672

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN St. Louis, Missouri)		c. CITY (If outside corporate limits, write RURAL and give township) 17 th TOWN ST. LOUIS 2-179	
c. LENGTH OF STAY (in this place) 2 DYS		d. STREET ADDRESS (If rural, give location) 1515 Lafayette	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital # 1			

3. NAME OF DECEASED (Type or Print)	a. (First) ROBERT	b. (Middle) H.	c. (Last) HOEHN	4. DATE OF DEATH (Month) (Day) (Year) Nov. 29 1951
-------------------------------------	-------------------	----------------	-----------------	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH Nov. 6, 1881	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-------------	------------------------	--	-------------------------------	------------------------------------	-----------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ELEVATOR OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST. LOUIS MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	--	-------------------------------------

13a. FATHER'S NAME HENRY HOEHN	13b. MOTHER'S MAIDEN NAME ANNA GRABCY	14. NAME OF HUSBAND OR WIFE CATHERINE HOEHN
--------------------------------	---------------------------------------	---

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 ADDRESS CATHERINE TIDD 2913 ^a WYOMING
--	-------------------------	--

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 mos.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease 2 years DUE TO (c) Hypertensive Cardiovascular Disease years		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Emphysema			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT (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? 4200
--	--	---------------------------------

22. I hereby certify that I attended the deceased from 11/27, 1951, to 11/29, 1951, that I last saw the deceased alive on November 29, 1951, and that death occurred at 3:38 PM, from the causes and on the date stated above.

23a. SIGNATURE Charles John Jennings, M.D.	23b. ADDRESS 1515 Lafayette	23c. DATE SIGNED 11/29/51
--	-----------------------------	---------------------------

24a. BURIAL, CREMATION, REMOVAL, OR OTHER TREATMENT BURIAL	24b. DATE DEC. 3 1951	24c. NAME OF CEMETERY OR CREMATORY SS. PETERY PAUL CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
--	-----------------------	---	---

DATE REC'D BY LOCAL REG. DEC 1 1951	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutia 2906 Garrison
-------------------------------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

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.....

Samuel C. Will

Licensed Embalmer No.

4347

P. O. Address.....

2906 Stevens

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.