

FILED APR 11 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12823**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 974

|  |                               |   |  |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission):<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Olivette</u>   |                               | c. LENGTH OF STAY (In this place) <u>6 yrs.</u>   |  |
| c. CITY (If outside corporate limits, write RURAL and give township) <u>Olivette</u>   |                               | d. STREET ADDRESS (If rural, give location) <u>1110 Dielman</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1110 Dielman</u>  |                               | e. STREET ADDRESS <u>1110 Dielman</u>   |  |
| 3. NAME OF DECEASED<br>(Type or Print) (First) <u>Emily</u> (Middle) <u>Katherine</u> (Last) <u>Hoots</u>  |                               | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 2 1953</u>   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>   | 8. DATE OF BIRTH <u>April 15 1881</u>  |
| 9. AGE (In years last birthday) <u>71</u>  |                               | 10. IF UNDER 1 YEAR Months _____ Days _____   | 11. IF UNDER 1 HR. Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Private home</u>   | 11. BIRTHPLACE (State or foreign country) <u>Illinois</u>                              |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |                               | 13a. FATHER'S NAME <u>John B. Fensterman</u>  |  |
| 13b. MOTHER'S MAIDEN NAME <u>Anna Pieper</u>   |                               | 14. NAME OF HUSBAND OR WIFE <u>Clarence F. Hoots</u>  |  |
| 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. <u>348-01-1497</u>  | 17. INFORMANT'S SIGNATURE OR NAME <u>Clarence F. Hoots</u> ADDRESS <u>1110 Dielman</u> |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  |                               | MEDICAL CERTIFICATION:<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocardial Infarction</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u><br><br>ANTECEDENT CAUSES <u>Arteriosclerotic Heart Disease</u><br>DUE TO (b) <u>Hypertension</u><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. _____ |  |
| 19a. DATE OF OPERATION <u>none</u>   |                               | 19b. MAJOR FINDINGS OF OPERATION _____  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               | 4200  |  |
| 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 <u>7/9</u> , 19 <u>52</u> , to <u>4/2</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>53</u> , and that death occurred at <u>6:40 P.m.</u> , from the causes and on the date stated above. |                               |   |  |
| 23a. SIGNATURE <u>Ruben S. Warner MD</u> (Degree or title)   |                               | 23b. ADDRESS <u>115 Paul Brown Bldg. St. Louis, Mo</u>  |  |
| 23c. DATE SIGNED <u>april 2 1953</u>   |                               | 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>  |  |
| 24b. DATE <u>4-3-53</u>  |                               | 24c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS EVANG. CEM.</u>   |  |
| 24d. LOCATION (City, town, or county) (State) <u>MADISON Co., ILL.</u>   |                               | DATE REC'D BY LOCAL REG. <u>4-3-53</u>  |  |
| REGISTRAR'S SIGNATURE <u>Herbert R. Daulton - M.D.</u>   |                               | 25. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Welser</u> ADDRESS <u>Edwardsville Ill.</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 B. H. Welch

Licensed Embalmer No. 3208

P. O. Address Edwardsville, Ill.

**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.