

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38849

State File No. _____
Registrar's No. **10091**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN ST. LOUIS MO		c. CITY OR TOWN ST. LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION PARK LANE HOSPITAL		e. STREET ADDRESS (If rural, give location) 2346 S. COMPTON	
3. NAME OF DECEASED (Type or Print) a. (First) PAULINE b. (Middle) - c. (Last) HOEGEMANN		4. DATE OF DEATH (Month) (Day) (Year) Nov. 6 1954	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 27, 1896 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and State or Foreign Country) Missouri
12. CITIZEN OF WHAT COUNTRY? U-S-A		13a. FATHER'S NAME FRANK MARSCHER	
13b. MOTHER'S MAIDEN NAME FRANCES FELL		14. NAME OF HUSBAND OR WIFE FRED HOEGEMANN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME FRED HOEGEMANN		ADDRESS 2346 S. COMPTON	

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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal Obstruction		INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES 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 11/4/54	19b. MAJOR FINDINGS OF OPERATION Intestinal obstruction		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 5705	

22. I hereby certify that I attended the deceased from **Nov. 3, 1954**, to **Nov. 6, 1954**, that I last saw the deceased alive on **Nov. 6, 1954**, and that death occurred at **4445A st.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thomas R. Guthrie		23b. ADDRESS 4930 Lindell Blvd.	23c. DATE SIGNED 11/6/54
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE Nov. 8 1954	24c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PK.	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
DATE REC'D BY LOCAL REG. NOV 8 1954	REGISTRAR'S SIGNATURE Charles Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Thomas R. Guthrie 2906 Garvia ADDRESS	

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.....
Signature of Student Embalmer

Signed.....

Leo J. Budde
Licensed Embalmer No. *39*
P. O. Address *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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.