

34838

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 15 1955

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

REG. DIST. NO. \_\_\_\_\_

318

PRIMARY REG. DIST. NO. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

9345

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri				b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 4 days		c. CITY OR TOWN Velda Village		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital				e. STREET ADDRESS (If rural, give location) 7005 Myron							
3. NAME OF DECEASED (Type or Print)			a. (First) ZELLA		b. (Middle) CATHERINE		c. (Last) HOENIG		4. DATE OF DEATH (Month) (Day) (Year) Oct. 25 1955		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan. 7, 1889		9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Homemaker			11. BIRTHPLACE (City and State or Foreign Country) Illinois			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Jake Phegley			13b. MOTHER'S MAIDEN NAME Sarah (Unknown)			14. NAME OF HUSBAND OR WIFE John Hoenig					
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. 500-32-8565		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Oscar J. Hoenig 9856 Meadowview Dr.							
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) <i>Infection of myocardium</i>  ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <i>arteriosclerotic coronary thrombosis.</i>  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>						INTERVAL BETWEEN ONSET AND DEATH 4 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 420.1						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) 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>Oct. 22, 1955</u> , to <u>Oct. 25, 1955</u> , that I last saw the deceased alive on <u>Oct. 25, 1955</u> , and that death occurred at <u>8:45 pm.</u> , from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) <i>John T. Linton, M.D.</i>				23b. ADDRESS 539 N. Grand Blvd.				23c. DATE SIGNED Oct. 26, 1955			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 28, 1955		24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens		24d. LOCATION (City, town, or county) (State) St. Louis Mo.					
DATE REC'D BY LOCAL REG. OCT 26 1955		REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>McCullen &amp; Kelly</i> 7267 Natural Bridge					

(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.....  
Signature of Student Embalmer

Signed *James A. Lammert*.....

Licensed Embalmer No. *4*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.