

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39480

FILED NOV 28 1956

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10126**

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 622 Eastgate			Length of stay in lb 30 yrs.		STREET ADDRESS 622 Eastgate		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) EMIL HOENIG				4. DATE OF DEATH Nov. 5, 1956		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14, 1897		9. AGE (In years last birthday) 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Retail		10b. KIND OF BUSINESS OR INDUSTRY Grocer		11. BIRTHPLACE (City and state or country) Hungary		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk. Hoenig				14. MOTHER'S MAIDEN NAME Unk.			
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. Unk.		17. INFORMANT Address Irene Hoenig 622 Eastgate			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL Hemorrhage DUE TO (b) Hypertension DUE TO (c) 331x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH One hour	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 7-15-58 to 11-5-56 and last saw him him alive on 11-5-56 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>[Signature]</i> (Degree or title) M.D.				22b. ADDRESS 4500 Olive-		22c. DATE SIGNED 11/6/56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		23b. DATE 11/7/56	23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol		23d. LOCATION (City, town, or county) (State) Ladue, Mo.		
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson			25. DATE RECD. BY LOCAL REG. NOV 7 1956		26. REGISTRAR'S SIGNATURE <i>[Signature]</i> M. J. B.		

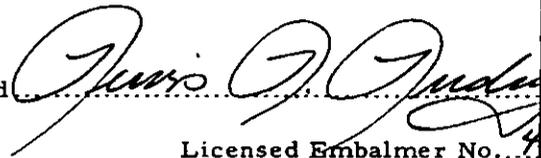
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1501 11 23

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed .....
Licensed Embalmer No.....

P. O. Address

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