

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11643**

FILED MAR 18 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **346**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____	
b. CITY OR TOWN <b>Carsonville</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>4 days</b>		e. STREET ADDRESS (If rural, give location) <b>209 2541 a Dodier St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Penn Nursing Home</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b> b. (Middle) <b>B.</b> c. (Last) <b>Hirschbuehler</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 4 1957</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>July 8 1874</b>	
9. AGE (in years last birthday) <b>82</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done for most of working life, even if retired) <b>Box Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brown Shoe</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Germany</b>
		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		

13a. FATHER'S NAME <b>Rudolph Hirschbuehler</b>	13b. MOTHER'S MAIDEN NAME <b>Clara Walz</b>	14. NAME OF HUSBAND OR WIFE <b>Mary Hirschbuehler</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>490 03 9571</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Robert Hirschbuehler</b> ADDRESS <b>5011 Durant</b>	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Arteriosclerotic Cerebrovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs.</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>vascular disease</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 _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **Dec 10 1946**, to **Feb 4 1957**, that I last saw the deceased alive on **Dec 18 1957**, and that death occurred at **6:15p m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>William J. Mayhew</b> (Degree or title) _____	23b. ADDRESS <b>2739 No. Grand</b>	23c. DATE SIGNED <b>2-5-57</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2/7/57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
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DATE REC'D BY LOCAL REG. <b>2-6-57</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Tomkins</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Buchholz Mortuary</b> ADDRESS <b>5967 W. Florissant</b>
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(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 *Walter M. Brubaker*.....

Licensed Embalmer No. *4557*.....

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.