

Health,  
& Welfare  
Public  
Service

FILED JUN 12 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18128  
STATE FILE NUMBER

Registration District No. 273 Primary Registration District No. 3051 Registrar's No. 55

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Perry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Perry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Perryville</u>		c. CITY OR TOWN <u>Perryville</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS	
Length of stay in lb <u>Life</u>		(If outside, give location) <u>410 Edgemont</u>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>William John Hoehn</u>			4. DATE OF DEATH Month Day Year <u>May 29 1957</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31 1881</u>	9. AGE (In years last birthday) <u>76</u>	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Perry County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
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13a. FATHER'S NAME <u>John Hoehn</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara Bergman</u>		14. NAME OF HUSBAND OR WIFE <u>Barbara Hoehn</u>	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>495-18-6768</u>		17. INFORMANT Address <u>Mrs Katherine Lintner Perryville Mo</u>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wk.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____			DUE TO (c) <u>332x</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
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20c. TIME OF INJURY Hour Month, Day, Year <u>8:15 p.m.</u>			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20e. CITY, TOWN, OR LOCATION COUNTY STATE		
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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	
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21. I attended the deceased from 1-29-57 to 5-29-57 and last saw her alive on 5-29-57  
Death occurred at 8:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. F. Fairchild, M.D.</u>		22b. ADDRESS <u>Perryville, Mo.</u>		22c. DATE SIGNED <u>5-1-57</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 1-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>		23d. LOCATION (City, town, or county) (State) <u>Perryville-Missouri</u>	
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24. FUNERAL DIRECTOR <u>Young Sons Perryville</u>		25. DATE RECD. BY LOCAL REG. <u>6-4-57</u>		26. REGISTRAR'S SIGNATURE <u>Jose J. Zellmer</u>	
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Wallace Young* .....

Licensed Embalmer No. *4027* .....

P. O. Address *Perryville* .....

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.