

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37583  
STATE FILE NUMBER  
318  
1003  
Registration District No. 1003 Registrar's No. 9535

S. 300  
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 4415a Athlone Ave.,		d. STREET ADDRESS (If outside, give location) 4415a Athlone Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last George H Hoelscher		4. DATE OF DEATH Month Day Year October, 10, 1957.	
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. 28, 1877
9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber (Retired)	11. BIRTHPLACE (City and state or country) Washington, Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Herman Hoelscher		13b. MOTHER'S MAIDEN NAME Kathryn Helling	14. NAME OF HUSBAND OR WIFE Elizabeth Hoelscher
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. 488-09-9665	17. INFORMANT Address Elizabeth Hoelscher, 4415a Athlone Avenue
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>Gastric Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Esophageal Varices</u> DUE TO (c) <u>Arterio Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>6 mo.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>450.0</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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
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 <u>Oct 8, 1957</u> to <u>Oct 10, 1957</u> and last saw her/him alive on <u>Oct. 10, 1957</u> Death occurred at <u>6 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>N.J. Horvich M.D.</u> (Degree or title)		22b. ADDRESS <u>8902 Riverview Blvd.</u>	
		22c. DATE SIGNED <u>10-11-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct 14 1957	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Missouri	
24. FUNERAL DIRECTOR Math. Hermann & Son Inc. 2161 E. Fair Ave.		25. DATE RECD. BY LOCAL REG. OCT 14 '57	
26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u> MJS			

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 *Clement W. Neary* .....

Licensed Embalmer No. *3732* .....

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.