

Health,
& Welfare
Public
Service

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 23 1958

47567
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12464

| | | | | | | | |
|---|----------------------------------|---|--|--|---|--|--|
| 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 | | 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 Christian Hospital | | | Length of stay in lb 4 days | | STREET ADDRESS 331 Antelope | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Walter Hotzel | | | | 4. DATE OF DEATH Month Day Year December 26th 1957 | | | |
| 5. SEX Male <input checked="" type="checkbox"/> | 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 October 1st 1892 | | 9. AGE (In years last birthday) 65 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder | | 10b. KIND OF BUSINESS OR INDUSTRY St. L. Mallabe | | 11. BIRTHPLACE (City and state or country) Dayton Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Hetzel | | | | 14. MOTHER'S MAIDEN NAME Belle Strunk | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.I. | | 16. SOCIAL SECURITY NO. 275-16-4929 | | 17. INFORMANT Address Dolores Hetzel 331 Antelope | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Arteriosclerotic Heart Disease</i> DUE TO (b) <i>Hypertension</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.0 | | | | | | | |
| 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 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 1950 to Dec 26-57 and last saw her alive on Dec 5-57 Death occurred at 9 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) John A. Morris MD | | | | 22b. ADDRESS 8209 E Broadway | | 22c. DATE SIGNED 12/26-57 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 12-30-57 | 23c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | 23d. LOCATION (City, town, or county) Columbus, Ohio | | (State) |
| 24. FUNERAL DIRECTOR ADDRESS Diedrich Funeral Home 8319 Hallsferry | | | 25. DATE RECD. BY LOCAL REG. DEC 26 57 | | 26. REGISTRAR'S SIGNATURE J. Earl Smith MD | | |

mks

MAY 13 1958

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 *Robert M. Murray*

Licensed Embalmer No. 37

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.