

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012598

STATE FILE NUMBER

FILED MAR 20 1958

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 753

300  
-57  
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1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ferguson</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>37 Halls Ferry Memorial Home</b>		Length of stay in lb <b>2 Days</b>	d. STREET ADDRESS (If outside, give location) <b>4204 College Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>John F. Hoyer</b>			4. DATE OF DEATH Month <b>3</b> Day <b>12</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sep. 25, 1875</b>		9. AGE (In years & birthday) <b>82</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) <b>Electrotypist (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.P. Electrotype</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>August Hoyer</b>		13b. MOTHER'S MAIDEN NAME <b>Philipine Kennel</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Olinda Hoyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk.</b>		17. INFORMANT Address <b>Mrs. Olinda Hoyer 4204 College Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>pulmonary fibrosis &amp;</b>					
DUE TO (c) <b>pulmonary emphysema</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>527.1</b>					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 <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 <b>Dec 27, 1958</b> to <b>Mar 12, 58</b> and last saw <b>him</b> alive on <b>Mar 11, 58</b> Death occurred at <b>1:15 P</b> on the date stated, above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>H. H. Siesener M.D.</b>			22b. ADDRESS <b>6000 W. Florissant</b>		22c. DATE SIGNED <b>3-14-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>3/15/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Drehmann-Harral, 1905 Union Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>3-14-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert P. Donke M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. H. H. Slesner  
6000 W. Florissant  
Ev 3-0127  
Hrs. 1-5 Fr. 1.

### 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 *Warren A. Carter* .....

Licensed Embalmer No. *3535* .....

P. O. Address .....

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.