

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016774
STATE FILE NUMBER

FILED MAY 12 1958

Registration District No. 317

Primary Registration District No. 546

Registrar's No. 1178

300
-57
00

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Overland		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Overland 4000
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2419 Oakland Ave. 16 Yrs.		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 2419 Oakland Ave.
			Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Alma Middle Henrietta Last Hoerath			4. DATE OF DEATH Month 4 Day 27 Year 1958			
--	--	--	---	--	--	--

5. SEX Female	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 Dec. 18, 1902	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
-------------------------	----------------------------------	---	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Cedar Fork, Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	--	--	---

13a. FATHER'S NAME Henry Flottmann	13b. MOTHER'S MAIDEN NAME Minnie Kraemer	14. NAME OF HUSBAND OR WIFE Martin Hoerath
--	--	--

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. None	17. INFORMANT Address Mr. Martin Hoerath, 2419 Oakland Av.
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage into gut + pharynx		INTERVAL BETWEEN ONSET AND DEATH 4 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Sarcoma of abdomen - massive	
	DUE TO (c) Sarcoma of Uterus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 174X		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 <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	

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 **3-58** to **4/27-58** and last saw her ^{alive} on **4-25-58**
Death occurred at **6:45 A.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Rolande Bluebrier MD	22b. ADDRESS 25 No Central Ave Clayton	22c. DATE SIGNED 4/29/58
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4/30/58	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
--	-----------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral, 1905 Union Blvd.	25. DATE RECD. BY LOCAL REG. 4-29-58	26. REGISTRAR'S SIGNATURE Herbert A. Dumble MD
--	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

84

Dr. Roland W. Stuebner
35 N. Central.
Pa 5-2222
Hrs. 1-5 Mon. & Tues.

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. *353*

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.