

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027055
STATE FILE NUMBER

FILED AUG 7 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7143

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saint Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		c. CITY OR TOWN Affton 4870	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bro. Hospital		d. STREET ADDRESS (If outside, give location) 7917 LaBelle	
3. NAME OF DECEASED (Type or print) First George Middle Hohenshell Last Hohenshell		4. DATE OF DEATH Month July Day 18 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 27, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Warehouse	11. BIRTHPLACE (City and state or country) Cairo, Illinois
13a. FATHER'S NAME Fred Hohenshell		13b. MOTHER'S MAIDEN NAME Lucy Wiley	14. NAME OF HUSBAND OR WIFE Ida Walde Hohenshell
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. 492-09-5858	17. INFORMANT Address Mrs. Ida Hohenshell 7917 LaBelle, Affton
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			3314
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____			
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 July 12, 1958 to July 18, 1958 and last saw her/him alive on July 18, 1958 . Death occurred at 6:10 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Carl Smith MD (Degree or title)		22b. ADDRESS 3606 Gravoia	22c. DATE SIGNED 7-19-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-21-58	23c. NAME OF CEMETERY OR CREMATORY Our Redeemer Cemetery	23d. LOCATION (City, town, or county) (State) Saint Louis County, Missouri
24. FUNERAL DIRECTOR Beiderwieden F.H.Inc. 1936 St.Louis Av.		25. DATE RECD. BY LOCAL REG. JUL 21 1958	26. REGISTRAR'S SIGNATURE Carl Smith MD MSB

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 _____

Licensed Embalmer No. 452

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.