

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004065  
STATE FILE NUMBER

FILED FEB 2 1959 Registration District No. 319 Primary Registration District No. 6079 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <b>STE. GENEVIEVE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>STE. GENEVIEVE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>STE. GENEVIEVE T.S.</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>WEINGARTEN</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>RR #1</b>	Length of stay in 1b <b>LIFE</b>	d. STREET ADDRESS (If outside, give location) <b>RR #1</b>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>HENRY JOSEPH HOGENMILLER</b>			4. DATE OF DEATH Month Day Year <b>JAN 28 1959</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>NOV 14 1880</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	--	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>WEINGARTEN MO</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	-----------------------------------	--	--

13a. FATHER'S NAME <b>JOSEPH HOGENMILLER</b>	13b. MOTHER'S MAIDEN NAME <b>ROSINA MURSSIC</b>	14. NAME OF HUSBAND OR WIFE <b>ANNA BIESER</b>
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>492-44-2061</b>	17. INFORMANT Address
---	---	-----------------------

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>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Myocarditis</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 Death occurred at <b>7:55 P.</b> on <b>Oct. 10, 1958</b> and last saw him alive on <b>Jan. 27, 1959</b> m of the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <b>Dr. Lawrence M. S. St. Genevieve Mo.</b>	22b. ADDRESS	22c. DATE SIGNED <b>1/29/59</b>
---	--------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>JAN. 31 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LADY HELP OF CHRISTIANS</b>	23d. LOCATION (City, town, or county) (State) <b>WEINGARTEN MO</b>
--	----------------------------------	--	---

24. FUNERAL DIRECTOR <b>Geo. C. Sachs</b>	ADDRESS <b>St. Genevieve Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Jan 30, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Willie Bala</b>
--	------------------------------------	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Adrian J. Ehler* .....

Licensed Embalmer No. *4740* .....

P. O. Address *Sta. Demencia* .....

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.