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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007223
STATE FILE NUMBER

FILED MAR 10 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1736

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP. #1. Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY
c. CITY OR TOWN: ST LOUIS Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3127 LOCUST ST Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: HANS Middle: — Last: HIRSCH
4. DATE OF DEATH Month Day Year: FEB. 17, 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY-9-1884
9. AGE (In years last birthday): 74 IF UNDER 1 YEAR Months: 9 Days: 8 IF UNDER 24 HRS. Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: BOOK KEEPER
11. BIRTHPLACE (City and state or country): GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: CARL OTTO HIRSCH
13b. MOTHER'S MAIDEN NAME: AUGUSTA DIENSTBACH
14. NAME OF ~~HUSBAND~~ OR WIFE: ANNA (DECEASED)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.
17. INFORMANT: MR JOHN HIRSCH Address: 3508 LONGVIEW DR MEHLVILLE MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Encephalomalacia + old myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c) 332X
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 ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 WORK ☐ NOT WHILE AT WORK ☐
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 1/28/59 to 2/17/59 and last saw her/him alive on 2/17/59
Death occurred at 12:50 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R. Johnson (Degree or title) M.D.
22b. ADDRESS: 1515 LAFAYETTE AVE
22c. DATE SIGNED: 2/17/59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: FEB-20-1959
23c. NAME OF CEMETERY OR CREMATORY: MEMORIAL PARK PEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS CO. MO

24. FUNERAL DIRECTOR ADDRESS: FEY FUNERAL HOME, MEHLVILAE MO
25. DATE RECD. BY LOCAL REG.: FEB 18 '59
26. REGISTRAR'S SIGNATURE: Noal Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 V E Morris

Licensed Embalmer No. 3360

P. O. Address St. Louis Mo

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.