

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011017

STATE FILE NUMBER

2279

FILED MAR 20 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300

1-57

03

694

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in 1b <u>LIFETIME</u>	d. STREET ADDRESS (If outside, give location) <u>1912 MALLINCKRODT ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA NMN HOEIKER</u>			4. DATE OF DEATH Month Day Year <u>MARCH 4, 1959</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 17, 1884</u>
9. AGE (In years last birthday) <u>75</u>		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) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>ERNST BAUS</u>	
13b. MOTHER'S MAIDEN NAME <u>LOUISE SMITH</u>		14. NAME OF HUSBAND OR WIFE <u>BEN HOEIKER (Deceased)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>488-03-7370</u>	17. INFORMANT Address <u>MRS. W. C. BROWN 1516 KAPPEL DRIVE DELWOOD</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF CECUM WITH WIDESPREAD METASTASES</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>153.0</u>
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 Month, Day, Year a.m. p.m.			
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 <u>NOV. 8, 1956</u> to <u>MARCH 4, 1959</u> and last saw her/him alive on <u>MARCH 4, 1959</u> Death occurred at <u>5:05 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>C. O. Vermillion, M.D.</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>3/4/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>MARCH 6, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY MO</u>
24. FUNERAL DIRECTOR <u>Quetmeyer + Son</u>		ADDRESS <u>3934 N. 20th</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 5 '59</u>
		26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>	

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 *Robert M. Murray*.....

Licensed Embalmer No. *3749*.....

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.