

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015122

STATE FILE NUMBER

FILED MAY 12 1959

Registration District No.

Primary Registration District No.

Registrar No. 4154

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-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5328a Terry Ave.		Length of stay in lb 50 Yrs.	d. STREET ADDRESS 5328a Terry
3. NAME OF DECEASED (Type or print) First Middle Last Mary Anne Hoelscher			4. DATE OF DEATH Month Day Year 4 26 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1875
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 84
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) 4 Bielefeld Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Fred LeVecke		13b. MOTHER'S MAIDEN NAME Anne Neidermarok	14. NAME OF HUSBAND OR WIFE August E. Hoelscher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. George Wilken, 3 Lomond Dr.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>420.0</i>			INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs</i> <i>20 yrs</i>
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 type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 <i>1940</i> to <i>4-26-59</i> and last saw her alive on <i>4-23-59</i> Death occurred at <i>5 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Clara Jordan D</i>		22b. ADDRESS <i>6000 W. Flourant</i>	22c. DATE SIGNED <i>4-27-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>4/29/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Bethlehem Cemetery</i>	23d. LOCATION (City, town, or country) (State) <i>St. Louis County Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Drehmann-Harral, 1905 Union Blvd.</i>		25. DATE RECD. BY LOCAL REG. <i>APR 28 '59</i>	26. REGISTRAR'S SIGNATURE <i>Loal Smith M.D.</i>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. Charles Jost  
6000 W. Florissant  
Co 1-7269  
Hrs. 1-4 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. Carn* .....

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.