URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 2 0 1959

59–041984
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210490

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2712 So 9th ST.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: JOSEPH Middle: W Last: HOERIG
4. DATE OF DEATH: Month: NOV Day: 12th Year: 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: MAR 10 1886
9. AGE (last birthday): 73
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED RAILROAD
10b. KIND OF BUSINESS OR INDUSTRY: MACHINIST
11. BIRTHPLACE (City and state or country): ST. LOUIS MO
12. CITIZEN OF WHAT COUNTRY: U-S-A
13a. FATHER'S NAME: MARTIN HOERIG
13b. MOTHER'S MAIDEN NAME: REGINA GURK
14. NAME OF HUSBAND OR WIFE: LILLIE HOERIG
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: LILLIE HOERIG Address: 2712 So 9th ST

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): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — Years
DUE TO (c): 420.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 8/9/58 to 11/12/59 and last saw her/him alive on 11/12/59
Death occurred at 2:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Aaron Hendrix MD
22b. ADDRESS: 1410 So 12th ST.
22c. DATE SIGNED: 11/13/59

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: NOV 16 1959
23c. NAME OF CEMETERY OR CREMATORY: ST. PETER + PAUL
23d. LOCATION (City, town, or county): ST. LOUIS (State): MO
24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: NOV 14 1959
26. REGISTRAR'S SIGNATURE: Roand Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed Somer C Will

Signature of Student Embalmer

Licensed Embalmer No. 434

P. O. Address 2906 Pr

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.