

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042910

STATE FILE NUMBER

FILED NOV 8 0 1959 347 Primary Registration District No. 500 Registrar's No. 2728

1. PLACE OF DEATH a. COUNTY <b>Saint Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>	Length of stay in 1b <b>1 day</b>	c. CITY OR TOWN <b>NORWOOD COURT Saint Louis</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>Normandy Osteopathic</b>		d. STREET ADDRESS (If outside, give location) <b>5332 Gladstone Pl.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Hoemann</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>14,</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-14-59</b>	9. AGE (last birthday) <b>—</b>	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>	IF UNDER 24 HR Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (City and state or country) <b>Normandy, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>		
13a. FATHER'S NAME <b>James William Hoemann</b>		13b. MOTHER'S MAIDEN NAME <b>Carol Marvyne Chapman</b>		14. NAME OF HUSBAND OR WIFE <b>—</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mr. &amp; Mrs. James Hoemann</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cerebral anoxia (Medullary paralysis)</b>		<b>10 min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Respiratory failure</b>	<b>2 h</b>
	DUE TO (c) <b>Prematurity</b>	<b>6 1/2 h</b>
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 <b>7:50 AM</b> Month, Day, Year <b>10-14-59</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>
20f. CITY, TOWN, OR LOCATION <b>—</b> COUNTY <b>—</b> STATE <b>—</b>		

21. I attended the deceased from **7:50 AM 10-14-59** to **Exp. 10-14-59** and last saw her **him** alive on **10-14-59**  
 Death occurred at **2:22 PM 10-14-59** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>George D. Wohlschlaeger, D.O.</b>		22b. ADDRESS <b>6401 W. Florissant, Mo</b>	22c. DATE SIGNED <b>10-14-59</b>
23a. DATE OF CREMATION <b>Oct. 16, 1959</b>	23b. DATE <b>—</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Washington, Missouri</b>
24. FUNERAL DIRECTOR <b>Heberg &amp; Witt, Washington, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-16-59</b>	26. REGISTRAR'S SIGNATURE <b>Sam B. Murphy, M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_

Licensed Embalmer No. 3254

P. O. Address Washington

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.