

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6 3 9 5

FILED VS. DEC 21 1959 517

Registration District No. _____ Primary Registration District No. 500 Registrar's No. 3210

STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grover</u>		Length of stay in 1b <u>54 yrs</u>		c. CITY OR TOWN <u>Grover</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>H1 # 100</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>H1 # 100</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rose Hoehne</u>				4. DATE OF DEATH Month Day Year <u>12/1/59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>8/3/1865</u>	9. AGE (last birthday) <u>94</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR 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>Own home</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Gottfried Mertz</u>			13b. MOTHER'S MAIDEN NAME <u>Rosie Mathis</u>			14. NAME OF HUSBAND OR WIFE <u>John Hoehne</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>none</u>		17. INFORMANT Address <u>Clara Hoehne, Grover, Mo.</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>Cerebral apoplexy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Hypertensive cardiac renal disease</u> <u>10 yrs</u>	
DUE TO (c) <u>arteriosclerosis</u> <u>25 yrs.</u>							
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 a.m. p.m.		Month, Day, Year					
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>8-28-44</u> to <u>12-1-59</u> and last saw her alive on <u>6-21-1959</u> Death occurred at <u>8:00 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title)			22b. ADDRESS <u>Eureka, Mo.</u>			22c. DATE SIGNED <u>12-2-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/4/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John Cemetery,</u>		23d. LOCATION (City, town, or county) <u>Ellisville, Mo.</u> (State)		
24. FUNERAL DIRECTOR <u>Schrader Funeral Home, Ballwin, Mo.</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-3-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

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 Richard M. Ballwin

Licensed Embalmer No. 4584

P. O. Address Ballwin

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.