

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020516

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5249**

**FILED JUN 7 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY		c. CITY OR TOWN <b>St. 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>2829 Ohio</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2829 Ohio</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SOPHIE</b> Middle <b>M</b> Last <b>HOEFFNER</b>						4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>1962</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-25-1888</b>		9. AGE (last birthday) <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13a. FATHER'S NAME <b>Louis Schick</b>				13b. MOTHER'S MAIDEN NAME <b>Anna Thien</b>				14. NAME OF HUSBAND OR WIFE <b>Karl P Hoeffner</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give NO or unknown) (If yes, give NO or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Karl P Hoeffner</b> Address <b>2829 Ohio (18)</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 apoplexy and stroke</b>										<b>40 days</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.													
DUE TO (b) <b>Arteriosclerosis, Hypertension, stroke</b>										<b>10 yrs</b>			
DUE TO (c) <b>Arteriosclerosis</b>										<b>334X</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 checked="" 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.				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 <b>Jan 10 1960</b> to <b>May 22 1962</b> and last saw her alive on <b>5/22/62</b> Death occurred at <b>10 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Walter J. Kessler M.D.</i> (Degree or title)						22b. ADDRESS <b>506 Olive St</b>			22c. DATE SIGNED <b>5/24/62</b>				
23a. BURIAL, CREMATION, REINTERMENT <b>Removal</b>		23b. DATE <b>5-25-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>				23d. LOCATION (City, town, or county) <b>St. Louis Co. MO</b> (State)					
24. FUNERAL DIRECTOR <b>WINGBERMUEHLE 3819 So Grand Blvd</b> ADDRESS						25. DATE RECD. BY LOCAL REG. <b>MAY 24 1962</b>			26. REGISTRAR'S SIGNATURE <i>Karl Smith M.D.</i>				

USE BLACK INK OR TYPEWRITER RIBBON

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**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 *George Anglermehl*  
Licensed Embalmer No. 4611

P. O. Address *Blum 18 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.