

No. 2
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-17-39
X47370

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 24 1947 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35851**
Registrar's No. **9528**

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Deaconess Hospital
(d) Length of stay: _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME Donald Hoene
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive Single years
7. Birth date of deceased October 13, 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
00 0 0 9 hr. _____ min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

12. Name William Hoene

13. Birthplace St. Louis, Missouri

14. Maiden name Leona Spitz

15. Birthplace St. Louis, Missouri

16. (a) Informant William Hoene

(b) Address 4487a Bircher

17. (a) Burial (b) Date thereof Oct 15 '47

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bromschwig and Son, Funeral Home

(b) Address 4746 W. Florissant Ave.

19. (a) OCT 15 1947 (Date received local registrar)

J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(d) Street No. 4487 - Bircher
(e) Citizen of foreign country? No
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 14
year 1947 hour 3:00 minute 3:00 P.M.

21. I hereby certify that I attended the deceased from 10/13/47, 19, to 10/14/47, 19;
that I last saw him alive on 10/14/47, 19,
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity (gestation 30 weeks)
Due to _____

Due to _____
Other conditions none
(Include pregnancy within 3 months of death)

Major findings: no
Of operations: no

Of autopsy: no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature Audley R. Smith (M. D. or other) _____

Address 4952 Maryland Date signed 10/14/47

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER, FATHER

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.....

No Embalming....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, fact should be so stated above: