FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28985

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7255

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS, MISSOURI
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BARNES HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY
c. CITY OR TOWN St. Louis
d. Is Residence within limits of a city or incorporated town? Yes X No ☐
e. STREET ADDRESS (If rural, give location) 2209 2325 Dodier St.

3. NAME OF DECEASED (Type or Print) a. (First) ARTHUR b. (Middle) (Hoelskoetter) c. (Last) HOSTETTER

4. DATE OF DEATH (Month) AUGUST (Day) 3, (Year) 1954

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower
8. DATE OF BIRTH 9/30/1872
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR Months 8 Days 3 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman
10b. KIND OF BUSINESS OR INDUSTRY City Employee
11. BIRTHPLACE (City and State or Foreign Country) St. Louis
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Henry Hoelskoetter
13b. MOTHER'S MAIDEN NAME Hannah Schlueter
14. NAME OF HUSBAND OR WIFE Josephine Hoelskoetter
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. 486-18-4091
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Edw. Hoelskoetter 5565 Chamberlain

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 2 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES X NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 490 X

22. *I hereby certify that I attended the deceased from* 8-2- , 1954, *to* 8-3- , 1954, *that I last saw the deceased alive on* 8-3- , 1954, *and that death occurred at* 3:15P *m., from the causes and on the date stated above.*

23a. SIGNATURE C. F. Vermillion M.D. (Degree or title) M. D.
23b. ADDRESS BARNES HOSPITAL
23c. DATE SIGNED 8-4-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/6/54
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) St. Louis (State) Mo

DATE REC'D BY LOCAL REG. AUG 5 1954
REGISTRAR'S SIGNATURE J. Carl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert D. Lineaty 2228 St. Louis

(Licensed Embalmer's Statement on Reverse Side)