

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No. **10866**
Registered No. **2891**
St. Ward)

2. FULL NAME

(a) Residence. No. **1319² Marcus** St., **11** Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** | 4. COLOR OR RACE **White** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF **Alvina Henne**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec. 16, 1960**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	69	3	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Machinist**
(b) General nature of industry, business, or establishment in which employed (or employer) **Retired**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Mo**
(STATE OR COUNTRY)

10. NAME OF FATHER **Bernard Henne**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Unkown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

14. INFORMANT **Alvina Henne**
(Address) **1319² Marcus Ave**

15. FILED **21 1930** **May C. Starkey**
REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 19 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Oct. 5**, 19 **30**, to **Mar. 19**, 19 **30**
that I last saw him alive on **Mar. 19**, 19 **30** and that death occurred, on the date stated above, at **6:50 P** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Aortic Insufficiency
92A
82A (duration) **2** yrs. mos. da.

CONTRIBUTORY (SECONDARY) **Cerebral Apoplexy**
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **900A**
IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **Dr. Van Hoefen** M. D.

3/20, 19 30 (Address) **8313 Halls Ferry**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Dak Brow Cemetery**
St. Charles, Mo. DATE OF BURIAL **Mar 24, 1930**

20. UNDERTAKER **Drehmann, Haral** ADDRESS **1905 Union**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

6
1
10

Dr Van Hoepen
until 12 noon