

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.

1939 AUG 1

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

26004  
Do not use this space.

1. PLACE OF DEATH

(a) County JEFFERSON Registration District No. 415  
 (b) Township MERAMEC Primary Registration District No. 5580 Registered No. 12-28  
 (c) City \_\_\_\_\_ (d) Street No. ST. JOSEPH'S HILL INFIRMARY - EUREKA, MO., St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 3 yrs. 5 mos. 1 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME FRANK HENSEL

(a) Residence, No. ST. JOSEPH'S HILL INFIRMARY St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10 / 23 / 1863  
 7. AGE YEARS 75 MONTHS 8 DAYS 16 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. LABORER, RETIRED  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) OHIO 1

13. NAME JOSEPH HENSEL 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) PENNSYLVANIA 1

15. MAIDEN NAME KATHERINE MANSFIELD

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) PENNSYLVANIA

17. INFORMANT ST. JOSEPH'S HILL INFIRMARY (ADDRESS) Brother Conventure

18. BURIAL, CREMATION, OR REMOVAL PLACE St. James Co. Hospital DATE 7/17/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Louis K. Bump Merckwood

20. FILED 2 Jul 39 JAMES A. JOURNAL Local Registrar. 586

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 19, 1939

22. I HEREBY CERTIFY That I attended deceased from ap. 19, 1939, to July 7, 1939  
 I last saw him alive on July 7, 1939 Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:

Chronic Bronchitis  
 Other contributory causes of importance: 106 lb  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) Jesse S. Sargent, M. D.  
 \_\_\_\_\_ (Address) Eureka, Mo.

**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, .....

*Louis H Bopp Pa L.H.*, or by .....

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

Signed..... *Louis H Bopp*

Licensed Embalmer No. *921*

P. O. Address..... *Lakewood 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 this body is not embalmed, above space should be left blank.**