DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NOV 13 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34053

Registration District No. 1008 791

Primary Registration District No.

Registrar's No. 8591

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: De Paul Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Florissant NR
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Anna M. Henke. 59

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bernard Henke

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased May (Month) 14 (Day) 1891 (Year)

8. AGE: Years 48 Months 4 Days 22 If less than one day hr. min.

9. Birthplace Florissant. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business At home

MOTHER FATHER

12. Name Bernard Gerbes.

13. Birthplace Florissant (City, town, or county) Mo (State or foreign country)

14. Maiden name Kate Henrietta Benne

15. Birthplace Florissant (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature Ben Henke

(b) Address Florissant Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9 1939 (Month) (Day) (Year)

(c) Place: burial or cremation Florissant Mo

18. (a) Signature of funeral director Jos W Clark.

(b) Address 1135 Hodiamont Ave

19. (a) OCT 7 1939 (Date received local registrar) (b) J. F. Budnick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 6 year 1939 hour 7 minute 30 AM.

21. I hereby certify that I attended the deceased from 9-25-, 1939, to 10-6-, 1939, that I last saw her alive on 10-6-, 1939, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CVA Nephritis (Chronic)	1934
Due to	
Due to	
Other conditions Chr. myocarditis (Include pregnancy within 3 months of death)	1936

Major findings:
Of operations no
Of autopsy no

PHYSICIAN — Underline the cause to which death should be charged statistically

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

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

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

While at work? (e) Means of injury

23. Signature Roy Johnson (M. D. or other)

Address Ferguson Mo Date signed 10-6-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39

JUN 29 1945

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

Signed Alan J. Neely

Licensed Embalmer No. 3225

P. O. Address 1125 Hodiamont Ave

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.