

Nb. 2
1-4-41
5-17-39
I X28390

Registration District No. **1791** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis mo
(b) City or town St. Louis mo
(c) Name of hospital or institution BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County _____
(c) City or town Granite City (rural)
(If outside city or town limits, write "RURAL")
(d) Street No. Route 2 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM HERMAN HANFELDER
(b) If veteran, name war no (c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 11
year 1941 hour 12 minutes 30 P. M.

4. Sex MALE 5. Color or race W
6. (a) Single, widowed, married, divorced 1
(b) Name of husband or wife Mary Brunkhoff
6. (b) Age of husband or wife if alive 67 years
7. Birth date of deceased September 3 1879
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 11, 1941 to June 11, 1941.
that I last saw him alive on June 11, 1941.
and that death occurred on the date and hour stated above.

8. AGE: Years 62 Months 8 Days 8 If less than one day _____ hr. _____ min.

Immediate cause of death Peritonitis Duration _____
Due to leakage of duodenal stump following gastrectomy ✓
Due to _____

9. Birthplace Washington County Illinois
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation Farming

11. Industry or business _____
12. Name Frank Hanfelder
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Mary Schlegel
15. Birthplace Germany (City, town, or county) (State or foreign country)

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

16. (a) Informant F. N. Hanfelder
(b) Address Granite City Ill RR#2

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? _____

17. (a) _____ (b) Date thereof 6-14-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Johns Granite City Ills

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

18. (a) Signature of funeral director E. H. Schildmann
(b) Address Granite City Ills
19. (a) JUN 12 1941 (b) J. H. Bredack
(Date received local registrar) (Registrar's signature)

23. Signature J. H. Bredack (M. D. or other) _____
Address BARNES HOSPITAL Date signed 6-11-41

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

1180

Handwritten notes, possibly "1180"

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 *E. N. Schildmann*

Licensed Embalmer No. *440*

P. O. Address *Frank City, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 200 66
Registrar's No. 4878

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Burns
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Wm H. Honfelder

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-29-41 (b) J F Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH: Month June day 11 - 41
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis Duration _____
leakage duodenal
ulcer following
gastroenteritis

Due to _____
Due to Duodenal ulcer

Other conditions _____ (Include pregnancy within 3 months of death)
No malignancy

Major findings:
Of operations _____
Of autopsy 11732

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

