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4-41
7-39
X26390

Registration District No. _____

Primary Registration District No. 200

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Admitted 9/8/41
(Specify whether years, months or days) unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County COU
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1036 South 7th Street
(If rural, give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Michael J. Henneberry

3. (b) If veteran, name war World

3. (c) Social Security No. -

4. Sex Male 5. Color or race White 6. (e) Single, widowed, married, divorced Single

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

7. Birth date of deceased June 17, 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 2 21 hr. min.

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

10. Usual occupation Construction Work

MOTHER FATHER

11. Industry or business -
12. Name Unavailable
13. Birthplace Unavailable
(City, town, or county) (State or foreign country)
14. Maiden name Unavailable
15. Birthplace Unavailable
(City, town, or county) (State or foreign country)

16. (a) Informant M. Schelling

(b) Address Clinical Clerk, VAF, Jeff. Bks., Mo.

17. (a) BURIAL (b) Date thereof SEPT 11 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NATIONAL CEMETERY

18. (a) Signature of funeral director C. Hoffmeister

(b) Address 7814 S Broadway

19. (a) SEP 10 1941 (b) C. J. McEvoy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month September day 8th,
year 1941 hour 10:30 minute _____ p. M.

21. I hereby certify that I attended the deceased from September 8, 1941 to September 8, 1941
that I last saw him alive on September 8, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death MALARIA, TERTIAN. Duration Unkn.

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations -

Of autopsy No autopsy - refused.

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

(a) Accident, suicide, or homicide (specify) NO

(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? _____

While at work _____ (Specify type of place)

Signature L. M. COSHRAN, M.D. (M. D. or other)

Address Chief Medical Officer Date signed 9/9/41

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

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 *Linus C. Hoffmeister*
Licensed Embalmer No. *3871*
P. O. Address *7814 S Broadway*

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.