

Rev. 5-17-39
I 11951

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

25919
State File No. 6687
Registrar's No.

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis Mo.
(c) Name of hospital or institution: DePaul 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)

8. (a) PRINT FULL NAME HENRY Hess
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex M W 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Viola Hess 6. (c) Age of husband or wife if alive 24 years
7. Birth date of deceased MOVA 18 1913
(Month) (Day) (Year)

8. AGE: Years 29 Months 2 Days 18
If less than one day _____ hr. _____ min.

9. Birthplace St. Jacob Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Welder

11. Industry or business _____

MOTHER FATHER
12. Name Henry Hess
13. Birthplace Pin Oak Township Ill
(City, town, or county) (State or foreign country)
14. Maiden name Marie Cieszkowski
15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Viola Hess

(b) Address 4064 Maffit St. Louis Mo.

17. (a) Removal (b) Date thereof Aug 7 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edwardsville Ill.

18. (a) Signature of funeral director W.S. Strube
(b) Address Edwardsville Ill.
19. Aug 7 1942 (b) Ja T. [Signature]
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 000 17
(c) City or town St. Louis 7 11
(If outside city or town limits, write "RURAL")
(d) Street No. 4064 Maffit Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 6
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug. 1 1942 to Aug. 6 1942
that I last saw him in alive on Aug 6 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Lambert's Paralysis Duration _____
Causus degenerative change in 10 days
anterior horns of cord
Due to ovine infection following 1 day
er. brook of teeth
Due to _____

Other conditions (Include pregnancy within 3 months of death) Spinal

Major findings: Of operations _____
Of autopsy Yes See above
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? _____

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

23. Signature Reumer Kane (M. D. or other) _____
Address 1117 No. Grand Ave Date signed 8/6/42

SEP 24 1956

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.....

Wm. Lyons....., Registered Apprentice No. *306*
working under my personal supervision.

Signed.....

John Ketter
Licensed Embalmer No. *3880*

P. O. Address.....*St. Louis 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.