

NOV 13 1942

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 403

1. PLACE OF DEATH: Chickery  
(a) County St. Louis  
(b) City or town St. Charles City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Josephs 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: 96  
(a) State Missouri (b) County St. Louis  
(c) City or town Ferguson,  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. F. D. # 10  
(If rural, give location)  
(e) Citizen of foreign country?.....(Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME James Henke  
3. (b) If veteran, name war.....  
3. (c) Social Security No.....

4. Sex M 5. Color or race White  
6. (a) Single, widowed, married, divorced Single  
6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased October 16 1942  
(Month) (Day) (Year)

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

9. Birthplace St. Charles Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Nihil

11. Industry or business.....

MOTHER FATHER  
12. Name Larwence H. Henke  
13. Birthplace Florissant Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Brian Pottenbaum  
15. Birthplace Gerald Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Larwence H. Henke  
(b) Address 118 N. Florissant Rd.

17. (a) Burial (b) Date thereon Oct. 20, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Florissant Mo.

18. (a) Signature of funeral director R.M. White  
(b) Address 118 N. Florissant Rd. Ferguson, Mo.

19. (a) 10-20-42 (b) Clarence G. Webster  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18  
year 1942 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from Oct 18th 1942 to Oct 18th 1942  
that I last saw him alive on Oct 17th 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Renaluria  
Due to Twin bottles  
Due to.....  
Other conditions none  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations none  
Of autopsy none  
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)  
(c) Means of injury.....  
23. Signature B.L. Penber (M.D. or other)  
Address St. Charles, Mo. Date signed 10/20/42

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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. 3460-1

Registration District No. 310

Primary Registration District No. 3208

Registrar's No. 403

1. PLACE OF DEATH:

(a) County St Charles  
 (b) City or town St Charles city  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St Joseph Hosp.  
(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 \_\_\_\_\_ (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 \_\_\_\_\_

3. (a) PRINT FULL NAME

JAMES BERKE

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 16  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ 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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 12-3-42 (b) Clarence Gleason  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1942 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I first saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

1942

S-34651