

5. No. 2  
-11-10-39  
5-17-39  
PI X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 10 1944

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

4122

State File No. \_\_\_\_\_

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 21

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

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

3. (a) PRINT FULL NAME Henry Hilke  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race white 6. (a) 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 not known  
(Month) (Day) (Year)

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace not known 9  
(City, town, or county) (State or foreign country)

10. Usual occupation Farm laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name not known  
13. Birthplace " " 9  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name not known  
15. Birthplace " " 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ida C. Gentemann  
(b) Address O'Fallon Mo.

17. (a) Burial (b) Date thereof Jan. 13 44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Paul Mo.

18. (a) Signature of funeral director E.A. Keithly  
(b) Address O'Fallon Mo.

19. (a) 1-18-44 (b) Sherret. Co. Paul  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Charles 92  
(c) City or town St. Paul 0  
(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.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11  
year 1944 hour 3 minute A M.

21. I hereby certify that I attended the deceased from Dec 16 19 43 Jan 11 19 44  
that I last saw him alive on Jan 10 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Broken compensation  
Due to Chronic Myocarditis  
Due to Gen. Arteriosclerosis  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations in 930  
Of autopsy in  
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)  
(e) Means of injury \_\_\_\_\_  
23. Signature A. P. Perich, Schuch, M.D. (M. D. or other)  
Address St. Charles Mo. Date signed 1/18/44

1340

---

---

**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, above space should be left blank.**