

FILED MAY 13 1944
Registration District No. 1844

Primary Registration District No. 3058

Registrar's No. 70

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:
127 Lindenwood Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town St. Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 127 Lindenwood Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME John Herman Senden

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Anna Dehnbostel 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased October 20, 1859
(Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days 7 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER { 12. Name George Senden
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Bekebrède
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant John Senden
(b) Address St. Charles MO

17. (a) Burial (b) Date thereof Apr. 29, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lutheran Cemetery

18. (a) Signature of funeral director N. K. ... Paul

(b) Address 376 N. 7th St. St. Charles MO

19. (a) April 28, 1944 (b) Ernst G. Paul
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27
year 1944 hour 5 minute 20 A.M.

21. I hereby certify that I attended the deceased from June 26
1941 to April 27 1944
that I last saw him alive on April 25 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Uræmia Duration

Due to Arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 Vernon A. ... (M. D. or other) MD

Address St. Charles MO Date signed 4/28/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

1360

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 5-12-44

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 Arthur C. Bue

Licensed Embalmer No. 3151

P. O. Address St. Charles, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may
Registrar's No. 70

Registration District No. _____

Primary Registration District No. 3058

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:
(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

John H Bender

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 m

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

7. Birth date of deceased oct - 20 (Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days _____ (If less than one day) min.

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

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 1944 year _____ M. _____

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death Uremia Chronic nephritis arteriosclerosis 1 yr

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 131h

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

B
3
6930

SUPPLEMENTARY

MOTHER FATHER

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

uncert a schme

m.

St Charles, mo.

15651