

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
5673 Enright Ave.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Laser Hesse

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

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Widower  
 6. (b) Name of husband or wife Eva P. Hesse 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Nov. 27- 1856  
(Month) (Day) (Year)

8. AGE:  Years 87  Months 10  Days 26  If less than one day  
hr. min.

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

10. Usual occupation Wholesale

11. Industry or business Dry Goods

MOTHER FATHER  
 12. Name Michael Hesse  
 13. Birthplace Alsace Lorraine  
(City, town, or county) (State or foreign country)  
 14. Maiden name Clementine Hirsch  
 15. Birthplace Alsace Lorraine  
(City, town, or county) (State or foreign country)

16. (a) Informant Perle Hesse  
 (b) Address 5673 Enright Ave.

17. (a) Burial (b) Date thereof 10-25-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cemetery

18. (a) Signature of funeral director [Signature]  
 (b) Address 5216 Delmar Blvd.

19. (a) Oct 25 1944 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5673 Enright Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23  
 year 1944 hour 8:30 minute \_\_\_\_\_ P.M. M.

21. I hereby certify that I attended the deceased from Oct 23  
1944 to Oct 23 1944  
 that I last saw him alive on Oct 23 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis?  
 Due to \_\_\_\_\_

Due to Chronic nephritis?

Other conditions [Signature]  
(Include pregnancy within 3 months of death)

Major findings: [Signature]  
 Of operations \_\_\_\_\_  
 Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(c) 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 [Signature] (M. D. or other) \_\_\_\_\_  
 Address 4903 Delmar Date signed Oct 24

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

100  
 17  
 9

44

DEC 15 1944

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. 4029  
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.