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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 5 1945

Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3490

Primary Registration District No. 6076

Registrar's No. 2625

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since 12/20/44 (Specify whether years, months or days)

In this community -

2. USUAL RESIDENCE OF DECEASED:

(a) State: Illinois (b) County: St. Clair

(c) City or town: E. St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No.: 1523 Ohio Avenue
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country -

3. (a) PRINT FULL NAME: Charles C. McHENRY

3. (b) If veteran, name war: W.W.1

3. (c) Social Security No.: 330-18-0243

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Divorced

6. (b) Name of husband or wife: -

6. (c) Age of husband or wife if alive: - years

7. Birth date of deceased: October 2, 1900 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
44	2	28	hr. min.

9. Birthplace: Centralia, Illinois (City, town, or county) (State or foreign country)

10. Usual occupation: Bartender

11. Industry or business: -

FATHER
12. Name: Charles McHenry
13. Birthplace: Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Kate Bady
15. Birthplace: Illinois (City, town, or county) (State or foreign country)

16. (a) Informant:
(b) Address: Clinical Records, VAF, Jeff.Bks., Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan.2,1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Natl.Cem.Jef.Bks.

18. (a) Signature of funeral director: John J. Kelly

(b) Address: Carr & Lorio see

19. (a) JAN 2 1945 (Date received by local registrar) (b) E. G. McLaurens M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30 year 1944 hour 4:05 minute p. M.

21. I hereby certify that I attended the deceased from December 20, 1944 to December 30, 1944; that I last saw him alive on December 30, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
PULMONARY HEMORRHAGE.	10 min.
Due to Abscess, pulmonary, non-tuberculous.	Unknown
Other conditions (Include pregnancy within 3 months of death) Pneumonia, lobar, right upper lobe.	Unknown

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Major findings:
Of operations: No operation.
Of autopsy: No 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): no

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: W. A. GERMAN, M.D., (M. D. or other)

Address: MANAGER. Date signed 12/30/44

(Licensed Embalmer's Statement on Reverse Side)

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 .....

not embalmed

....., Registered Apprentice No. .....

working under my personal supervision.

Signed John J Kassly

Licensed Embalmer No. E 6855 see

P. O. Address East St. Louis, Ill

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.