

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **1872**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital #1.0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

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

(d) Street No. 710 Russell Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Fred Henneke

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

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

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

7. Birth date of deceased May 19 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>9</u>	<u>5</u>	_____ hr. _____ min.

9. Birthplace Perryville Mo. 10
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

12. Name Herman Henneke

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Unknown 9

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Harry T. Henneke
(b) Address 710 Russell Ave.

17. (a) Burial (b) Date thereof Feb. 28, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary-Cemetery

18. (a) Signature of funeral director Wacker-Heldner
(b) Address 3634 Gravois Ave.

19. (a) FEB 26 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24th
year 1945 hour 9:55 minute P M.

21. I hereby certify that I attended the deceased from 2/15/45
_____, 19____, to 2/24/45, 19____;
that I last saw h. in alive on 2/24/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic heart disease Duration

Due to _____

Due to hypertensive cardiovascular disease PHYSICIAN
Other conditions: auricular ventricular block,
complete due to unknown cause
Psychosis with other somatic disease

Major findings: _____
Of operations: _____
Of autopsy: _____

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 Ellis J. Lysak (M. D. or other) _____
Address 1515 Lafayette 2/24/45 signed _____

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

MOTHER, FATHER

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 *Robert Cochran*.....

Licensed Embalmer No. *2178*.....

P. O. Address *St Louis 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.