S. No. 2
I—8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 24 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7132

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 2642

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Clayton, Missouri. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 days (Specify whether
In this community 20 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Frank A. Henke
3. (b) If veteran, name war
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 Caroline Metzger
6. (c) Age of husband or wife if alive - years
7. Birth date of deceased Sept (Month) 13 (Day) 1859 (Year)

8. AGE: Years 85 Months 4 Days 21 If less than one day hr. min.

9. Birthplace Germany (City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business None
FATHER 12. Name Henry Henke
13. Birthplace Germany (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name -
15. Birthplace - (City, town, or county) (State or foreign country)
16. (a) Informant Anthony M. Henke
(b) Address 127 Habecking Dr. R.G.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5 Th 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Edward Koch
(b) Address 3516 N 14 Th Str
19. (a) JAN 5 1945 (Date received local registrar) (b) E. G. McGowan MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 3 year 1945 hour minute 9:45AM
21. I hereby certify that I attended the deceased from Dec 10, 1944 to 1-3-, 1945 that I last saw him alive on 1-3-1945, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death: arteriosclerotic Heart disease ?
Due to Diabetes ?
Due to
Other conditions (Include pregnancy within 3 months of death) fractured Hip 45 days
Decubital ulcer ?
Major findings:
Of operations
Of autopsy

Duration

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) Accident
(b) Date of occurrence 11-19-44
(c) Where did injury occur? Elms Cowes Home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Innings St Louis Mo (Specify type of place)
While at work? (e) Means of injury
23. Signature John A. Wilson (M. D. or other)
Address St. Louis County Hosp. Date signed 1-3-1945

(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.....

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

working under my personal supervision.

Signed Ronald Yahnke

Licensed Embalmer No. 3917

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.

No. 2B
—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7132

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 2642

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Clayton
(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)

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

3. (a) PRINT FULL NAME Frank A. Henke

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 Sept (Month) 13 (Day) 1859 (Year)

8. AGE: Years 85 Months 4 Days 2 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Day 3
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Simple inter-trochanteric fracture left femur	6 wks.
Arteriosclerotic heart disease	?
Due to Fall	
Due to	
Other conditions Diabetes mellitus (Include pregnancy within 3 months of death)	?

Major findings:
Of operations 1860
Of autopsy 1910

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) Accident

(b) Date of occurrence About ~~December~~ November 21, 1944

(c) Where did injury occur? Elms Convalescent Home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Elms Convalescent Home - Jennings - St Louis County Mo.
(Specify type of place)

While at work? No (e) Means of injury Fall

23. Signature John A. Wilson, (M. D. or other) M.D.

Address 601 Brentwood Blvd. Clayton, Mo. Date signed 5-28-45