

S. No. 2
DOM-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7874**

FILED MAR 28 1945 318

Registration District No. **1003**

Registrar's No. **2451**

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

1. PLACE OF DEATH:

(a) County **St. Louis, Mo.**

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

(c) Name of hospital or institution:
4244A Linton Ave. /
(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 **Missouri** (b) County _____

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

(d) Street No. **4244A Linton Ave.**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Blanche Engelken**

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

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Herbert Engelken** 6. (c) Age of husband or wife if alive **31** years

7. Birth date of deceased **July 14, 1904**
(Month) (Day) (Year)

8. AGE: Years **40** Months **8** Days **1** If less than one day hr. _____ min. _____

9. Birthplace **St. Charles, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Bernard Hembrock**

13. Birthplace **Old Monroe, Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Theresa Vehige**

15. Birthplace **Old Monroe, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Herbert Engelken**
(b) Address **4244A Linton Ave.**

17. (a) **Burial** (b) Date thereof **Mar. 19, 44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery Bromschiwig Und. Co.**

18. (a) Signature of funeral director _____
(b) Address **4746 West Florissant Ave**

19. (a) **MAR 16 1945** **J. F. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **15** year **45** hour **4** minute **050** A.M.

21. I hereby certify that I attended the deceased from **Mar 12** 19**45** to **Mar 15** 19**45** and that death occurred on the date and hour stated above.

that I last saw her alive on **Mar 15** 19**45**

Immediate cause of death **Cerebral Hemorrhage Rt.**
Severe Hypertension

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **g.g.**

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 **J. F. [Signature]** (M. D. or D. O.) _____
Address **4005 W. Florissant** Date signed **3-16-45**

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Isy W Wilkinson

Licensed Embalmer No..... *3575*

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.