. S. No. 2
M—8-43
v. 5-17-39
I X37823

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. 11350

Registration District No. FILED APR 27 1945 818

Primary Registration District No. 1003

Registrar's No. 3450

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: Parklane Hospital
(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: 91

(a) State Missouri (b) County St. Louis

(c) City or town Chesterfield Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Olive Street Road N.R.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME William H. Hollenberg

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Anna

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

7. Birth date of deceased April (Month) 26 (Day) 1879 (Year)

8. AGE: Years 65 Months 11 Days 21 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

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

MOTHER
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant William E. Hollenberg
(b) Address Chesterfield, Mo. R#2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-45 (Month) (Day) (Year)
(c) Place: burial or cremation Zion Lutheran Cem

18. (a) Signature of funeral director Baumann Bros Inc
(b) Address 2504-Woodson Rd-Overland

19. (a) APR 18 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ~~Feb 20 1945~~ April 16-45
year hour 5 minute 00 P M

21. I hereby certify that I attended the deceased from Feb 20-45, 19, to April 16-45, 19
that I last saw him alive on April 16, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Hemorragic Pleura Pneumonia

Due to

Other conditions Angina Pectoris
(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy no

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) none

(b) Date of occurrence

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none (Specify type of place)

While at work? (e) Means of injury none

23. Signature D. M. F. Harmann (M. D. or other)
Address 2739 N Grand St Louis Mo Date signed 4/17-45

(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 D. G. Peterson

Licensed Embalmer No. 3767

P. O. Address Overland 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.