S. No. 2
M—8-43
. 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. 18324

FILED JUN 7 1945

Registration District No. 3[illegible] Primary Registration District No. 4469 Registrar's No. 30

**1. PLACE OF DEATH:**

(a) County STE. GENEVIEVE

(b) City or town STE. GENEVIEVE
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
602 3rd St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community LIFE
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County STE. GENEVIEVE

(c) City or town STE. GENEVIEVE
(If outside city or town limits, write "RURAL")

(d) Street No. 702 3rd. ST
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME FRANK X. HERZOG

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 LENA GOURO

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

7. Birth date of deceased DEC (Month) 1 (Day) 1864 (Year)

8. AGE: Years 80 Months 5 Days 21 If less than one day ..... hr. ..... min.

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

10. Usual occupation LABORER

11. Industry or business .....

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

MOTHER
14. Maiden name ODILE SCHILLY
15. Birthplace ZELL (City, town, or county) Mo (State or foreign country)

16. (a) Informant Max Al. Brown
(b) Address 2118 Edmond ave. St Louis Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-25-45 (Month) (Day) (Year)
(c) Place: burial or cremation STE. GENEVIEVE MO

18. (a) Signature of funeral director Leo C. Basler
(b) Address Ste Genevieve Mo

19. (a) May 24/45 (Date received local registrar) (b) T. W. Douglas (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month MAY day 22
year 1945 hour 4 minute 40 P. M.

21. I hereby certify that I attended the deceased from May 10, 1945, to May 22, 1945
that I last saw him alive on May 21, 1945
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Chronic Nephritis | 2 |
| Chronic Myocarditis | |
| Due to | |
| Due to | |
| Other conditions Ac. Uraemia (Include pregnancy within 3 months of death) | 5/10/45 |

Major findings:
Of operations .....
Of 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) .....
(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 R C Lanning (M. D. ~~or other~~)
Address Ste Genevieve Mo Date signed 5/23/45

706

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 645-667

Date Filed 6-6-45

## 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 Leo C. Barber

Licensed Embalmer No. 1985

P. O. Address Ste. Genevieve 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.**