

UNITED STATES BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **35377**
Registrar's No. **9626**

FILED NOV 19 1945
Registration District No. **318**

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Firman DesLoge Hospital 1)
(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

3. (a) PRINT FULL NAME Jennie Heib

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 Divorced

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

7. Birth date of deceased November 3, 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>0</u>	<u>1</u>	hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation at home

MOTHER FATHER

11. Industry or business _____

12. Name Charles van Tourenhout

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

14. Maiden name Sophia Jacques

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

16. (a) Informant Msgr C.L. van Tourenhout

(b) Address St. Genevieve Missouri

17. (a) Burial (b) Date thereof Nov. 7, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old SS. Peter & Paul Cm.

18. (a) Signature of funeral director Weick Bros.

(b) Address 2201 S. Grand Bl.

19. (a) NOV 6 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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. 1232a Sidney Street
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 4
year 1945 hour 9 minute 05 P. M.

21. I hereby certify that I attended the deceased from Oct 4, 1945 to Nov 4, 1945
that I last saw him alive on Nov 4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Infection of foot
minor trauma & diabetes

Due to trauma & diabetes

Due to _____

Other conditions 61
(Include pregnancy within 5 months of death)

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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature [Signature] (M. D. or other) _____

Address 2206 Lafayette Date signed Nov 6

Dr. Hunt
3206 Lafayette St.

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.....

Licensed Embalmer No. **3722**

P. O. Address **412 Duchouquette St.**

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.