

STANDARD CERTIFICATE OF DEATH

State File No.

11218

FILED JAN 5 1946
Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
3501 a University street /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 72 yrs, 6 Mo, 12 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Dr. August F. Henke

3. (b) If veteran, name war no

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 Alma Henke

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased June 7th 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	6	12	hr. min.

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

10. Usual occupation Physician

11. Industry or business Himself

12. Name Phillip Henke

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

14. Maiden name Louise Becker

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

16. (a) Informant Mrs Alma Henke (Wife)

(b) Address 3501 a University street

17. (a) Entombment (b) Date thereof 12-22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Mausoleum

18. (c) Signature of funeral director Suedmeyer & Sons

(b) Address 5934 North 20th street

19. (a) DEC 21 1945 (b) [Signature]
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County [unclear]

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

(d) Street No. 3501 a University street
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19
year 1945 hour 1 minute 40 P. M.

21. I hereby certify that I attended the deceased from Sept 5 to Dec 19
that I last saw him alive on Dec 18 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma, prostate Duration 6 Mo

Due to Metastasis spine & pelvis Duration 3 Mo

Other conditions _____

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) Means of injury _____

23. Signature [Signature] (M. D. or other) 12/45

Address 607 E. Grand Date signed 12/20

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

MAR 22 1950

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed A. G. Smithers
Licensed Embalmer No. 3916
P. O. Address 2626^a Union Bl.

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.