

**FILED JUL 22 1946**  
Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **1504**

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Florissant  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Box 269, R.R. #1.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Florissant  
(If outside city or town limits, write "RURAL")  
(d) Street No. Box 629, R.R. #1.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

William R. Hesse

3. (b) If veteran, name war None

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 Laura Hesse nee Moeller 6. (c) Age of husband or wife if alive 74 years  
7. Birth date of deceased June 16, 1871  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15, year 1946 hour 4:00 P.M. minute \_\_\_\_\_  
21. I hereby certify that I attended the deceased from May 9, 1946 to July 15, 1946  
that I last saw him alive on July 15 and that death occurred on the date and hour stated above.

Immediate cause of death angina pectoris  
Due to not known  
Due to 94-6

Duration

2 mo

Other conditions none  
(Include pregnancy within 3 months of death)  
Major findings: Of operations none  
Of autopsy none

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? \_\_\_\_\_ (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 O. H. Miller (M. D. or dentist)  
Address 94104 Greenwood Date signed 7/15/46

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>70</u>	<u>29</u>	hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Rudolph Hesse

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

14. Maiden name Christina Barnes

15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Laura F.L. Hesse

(b) Address Box 629 R.R. #1. Florissant, Mo.

17. (a) Burial (b) Date thereof 7/18/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Black Jack, Mo. Salem Cemetery

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) 7-17-46 (b) E. J. MacLauran, M.D.  
(Date received local registrar) (Registrar's signature)

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

7600

**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 *Raymond F. Liberman*  
Licensed Embalmer No. *4266*  
P. O. Address *St. Louis, 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.**