FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 15 1947

Registration District No. 97

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 29911

Registrar's No.

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8/25/47 to 9/7/47 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 109
(c) City or town Warrenton
(If outside city or town limits, write "RURAL")
(d) Street No. Route #1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME HENSIEK, Fred W.
3. (b) If veteran, name war WW-1
3. (c) Social Security No. Unknown
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Gertrude Hensiek
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased November (Month) 28 (Day) 1887 (Year)

8. AGE: Years 59 | Months 9 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Jonesburg, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business
FATHER
12. Name Fritz Hensiek
13. Birthplace New Melle (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Annabelle Legerman
15. Birthplace (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Registrar
(b) Address V.A. Hospital, Jeff.Bks., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-47 (Month) (Day) (Year)
(c) Place: burial or cremation Jonesburg, Mo.
18. (a) Signature of funeral director F.W. Nieburg & Co.,
(b) Address Warrenton, Missouri
19. (a) 9-9-47 (Date received local registrar) (b) Cecil A. Sharp (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 7 year 1947 hour 8:30 minute AM.
21. I hereby certify that I attended the deceased from August 25, 1947 to September 7, 1947; that I last saw him alive on September 7, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Occlusion	
Due to:	
Due to:	
Other conditions: Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) No
(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 L. E. Stikeleather (M. D. or other)
Address Vet. Adm. Hosp. Jeff. Brk. Mo. Date signed 9/7/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

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 John T. Lieberg

Licensed Embalmer No. 3897

P. O. Address Warrenton, 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.

. No. 2B
M—3-45
I X43880

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. Sept 1969

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. not given

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution
(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:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Fred W. Hensieli

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. 28 88
(Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 9-9-47 (Date received local registrar) (b) Ceulaz Stoy MD (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept 7
year 1947 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-29911