

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

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

11069

State File No. \_\_\_\_\_

FILED APR 5 1948

Registration District No. \_\_\_\_\_

Primary Registration District No. 6076

Registrar's No. 692

1. PLACE OF DEATH:

(a) County St Louis  
 (b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Hells Ferry Nursing Home  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4-1/2 wks  
(Specify whether  
 In this community Yes  
years, months or days)

3. (a) PRINT FULL NAME

Ida Henschel

3. (b) If veteran, name war No

3. (c) Social Security No. NO

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced 3  
 6. (b) Name of husband or wife Do not know 6. (c) Age of husband or wife if alive 3 years  
 7. Birth date of deceased Feb 28 1861  
(Month) (Day) (Year)

8. AGE: Years 87 Months 11 Days \_\_\_\_\_ If less than one day  
hr. min.

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

10. Usual occupation House work

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant No

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester Ave.

19. (a) 6-18-48 (b) Rowland Mortuary  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis 96  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Hells Ferry Nursing Home  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10  
 year 1948 hour 10:55 minute \_\_\_\_\_  
 21. I hereby certify that I attended the deceased from March 10  
1948 to March 10 1948  
 that I last saw her alive on March 10 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Due to Arterial Sclerosis

Due to 430

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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) (e) Means of injury

3. Signature A. J. Haver (M. D. or other) \_\_\_\_\_

Address 2739-41 92nd Date signed 3-11-48

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**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.....

P. O. Address.....

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 692

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)  
Name of hospital or institution:  
Halle Ferry nursing home  
(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)  
Halle Ferry Halle 4 yrs.

3. (a) PRINT FULL NAME Eda Henschel  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) ~~Single, widowed, married,~~  
divorced

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

7. Birth date of deceased 2 - 28  
(Month) (Day) (Year)

8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ (if less than one day)  
hr. \_\_\_\_\_ min.

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

10. Usual occupation Banker work

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

12. Name \_\_\_\_\_

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

14. Maiden name Eda Henschel

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funerary Home

18. (a) Signature of funeral director Richard D. ...

(b) Address 4104 Maple St

19. (a) 3-15-48 (b) Conrad Hoffmann  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis  
(c) City or town Halle Ferry Repland  
(If outside city or town limits, write "RURAL")  
(d) Street No. Halle Ferry nursing home  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar 1948  
year 1861 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from Mar 21  
1948 to Mar 10 1948  
that I last saw her alive on Mar 10 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis  
Duration \_\_\_\_\_

Due to Hypertension

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) hypertension

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 H. E. ... (M. D. or other)  
Address 2738 N. Grand Date signed 3-31-48

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

SUPPLEMENTARY

S-11069