

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41515**
Registrar's No. **11021**

FILED JAN 11 1949 **318**
Registration District No.

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
819 Market Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months (Specify whether years, months or days)

3: (a) PRINT FULL NAME Herman J. Henke
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W 2
6. (b) Name of husband or wife Christine 6. (c) Age of husband or wife if alive Dcd. years
7. Birth date of deceased Feb. 9 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 9 11 hr. min.

9. Birthplace St. Louis Mo. 11
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business.....

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Herman Henke

(b) Address R#1-Box 413 Robertson, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-48
(Month) (Day) (Year)

(c) Place: burial or cremation Fee Fee Cemetery

18. (a) Signature of funeral director Blumstein

(b) Address 2504 Woodson Rd Overland-11-Mo.

19. (a) DEC 21 1948 (Date received local registrar) J. B. Lacater (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 819-Market Street
25 (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 20
year 1948 hour 9 min 20 A. 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.

Immediate cause of death.....
Myocardial Infarction
Due to.....
Atherosclerosis
Due to.....
Other conditions.....
(Include pregnancy within 9 months of death)

Major findings:
Of operations.....
Of autopsy.....
Duration.....
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) (Specify means of injury)
26. Signature J. B. Lacater (M. D. or other).....
Date signed 12/21/48

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 Oscar F. Mueller

Licensed Embalmer No. 3039

P. O. Address Overland 14 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.