

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. 13604

FILED MAY 11 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1007 Registrar's No. 3906

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)<br>a. STATE <u>Mo.</u> b. COUNTY <u>HT</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>                                     |  |
| c. LENGTH OF STAY (in this place) <u>6 yrs</u>  |  | d. STREET ADDRESS (If rural, give location) <u>5408 S. Broadway</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The St. Louis Altenheim</u>                        |  |   |  |

|                                     |                         |                         |           |  |
|-------------------------------------|-------------------------|-------------------------|-----------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Henry</u> | b. (Middle) <u>Bley</u> | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year) <u>4 - 30 - 1949</u> |
|-------------------------------------|-------------------------|-------------------------|-----------|--|

|                    |                               |   |                                    |   |                 |                   |
|--------------------|-------------------------------|---|------------------------------------|---|-----------------|-------------------|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>12-13-1864</u> | 9. AGE (In years last birthday) <u>84</u> | IF UNDER 1 YEAR | IF UNDER 100 HRS. |
|                    |                               |   |                                    | Months                                    | Days            | Hours             |

|   |                                   |   |                              |
|---|-----------------------------------|---|------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil.</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | 12. CITIZEN OF WHAT COUNTRY? |
|---|-----------------------------------|---|------------------------------|

|                                   |  |   |
|-----------------------------------|--|---|
| 13a. FATHER'S NAME <u>UnKnown</u> | 13b. MOTHER'S MAIDEN NAME <u>UnKnown</u> | 14. NAME OF HUSBAND OR WIFE <u>Emma</u> |
|-----------------------------------|--|---|

|  |                         |  |                                 |
|--|-------------------------|--|---------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME <u>John W. Hoerr</u> | ADDRESS <u>5408 S. Broadway</u> |
|--|-------------------------|--|---------------------------------|

|   |   |  |  |
|---|---|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>14 days</u><br><br><u>?</u><br><br><u>?</u> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u>   |  |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Chr Myocarditis</u><br>DUE TO (c) <u>arterio sclerosis</u> |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>None</u>  |   |  |  |

|                        |  |  |
|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>None</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|--|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>St Louis</u> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Mo</u> |
|--|--|---|

|  |  |  |
|--|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>None</u> |
|--|--|--|

22. I hereby certify that I attended the deceased from March 18 43, to April 30, 19 49, that I last saw the deceased alive on April 30, 19 49, and that death occurred at 3:30 P m., from the causes and on the date stated above.

|   |                                |                                |
|---|--------------------------------|--------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Max Stadloff MD</u> | 23b. ADDRESS <u>512 Dow Pl</u> | 23c. DATE SIGNED <u>5/1/49</u> |
|---|--------------------------------|--------------------------------|

|   |                           |  |  |
|---|---------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>5-2-1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>St. Peters</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u> |
|---|---------------------------|--|--|

|  |  |   |                                   |
|--|--|---|-----------------------------------|
| DATE REC'D BY LOCAL REG. <u>MAY 1 1949</u> | REGISTRAR'S SIGNATURE <u>J B Nusaker</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. P. Fendler</u> | ADDRESS <u>7128 Michigan Ave.</u> |
|--|--|---|-----------------------------------|

(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

Student Embalmer No.

working under my personal supervision.

Signed

*Alvance Cochran*

Signed.....  
Student Embalmer

Licensed Embalmer No.

*30-93*

P. O. Address

*7128 Michigan*

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.