

FILED APR 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14359

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3068 Registrar's No. 709

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) Maplewood		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) Maplewood		d. STREET ADDRESS (If rural, give location) 7479 Hazel Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 7479 Hazel Ave.			d. STREET ADDRESS (If rural, give location) 7479 Hazel Ave.			
3. NAME OF DECEASED (Type or Print) William Arthur Henkel			4. DATE OF DEATH (Month) (Day) (Year) March 21, 1949			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 23, 1876	9. AGE (In years last birthday) 73	10. IF UNDER 1 YEAR 0 Months	11. IF UNDER 18 HRS. 18 Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Title Examiner		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME John L.O. Henkel		13b. MOTHER'S MAIDEN NAME Ann M. Smith		14. NAME OF HUSBAND OR WIFE Lenore Henkel		
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 ADDRESS Lenore Henkel 7479 Hazel Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiac decompensation DUE TO (c) Arteriosclerotic heart disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	930		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
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?				
22. I hereby certify that I attended the deceased from 11-6, 1947, to 3-21, 1949, that I last saw the deceased alive on 3-21, 1949, and that death occurred at 5 P. m., from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) Stanford Phillips M.D.			23b. ADDRESS 1117 N. Union		23c. DATE SIGNED 3-22-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-24-1949	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cem.		24d. LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REG. 3/23/49	REGISTRAR'S SIGNATURE Thurid Lunge		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jay B. Smith 7456 Manchester Rd.			

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.

Student
Student Embalmer

Signed

J.P. Burgess

Licensed Embalmer No. *4029*

P. O. Address *Maplewood*

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.