

BIRTHDAY **FILED DEC 30 1952** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **3189**

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>JEFFERSON BARRACKS, MO.</b>		c. CITY OR TOWN <b>PINE LAWN</b>	
c. LENGTH OF STAY (in this place) <b>164 DAYS</b>		d. STREET ADDRESS (If rural, give location) <b>4007 JENNINGS ROAD</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>EDWARD</b>	b. (Middle) <b>J.</b>	c. (Last) <b>ENZENAUER</b>	12-12-52		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11-16-06</b>	9. AGE (In years last birthday) <b>46</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARBER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BARBER SHOP</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>BALDWIN, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>THEODORE ENZENAUER</b>	13b. MOTHER'S MAIDEN NAME <b>BERTHA GERMAN</b>	14. NAME OF HUSBAND OR WIFE <b>MILDRED ENZENAUER</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES WW-II</b>	16. SOCIAL SECURITY NO. <b>495180956</b>	17. INFORMANT'S SIGNATURE OR NAME <b>VA HOSPITAL RECORDS, JEFF BRKS, MISSOURI</b>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CARCINOMA OF LARYNX WITH METASTES TO CERVICAL AND MEDIASTINAL LYMPH NODES,</b>		DUE TO (b) <b>LEFT AURICLE LUNGS AND LIVERS</b>		<b>2 YRS.</b>
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		DUE TO (c) <b>161X</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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) <b>VA</b>	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 **7-1-52**, 19**52**, to **12-12-52**, and that death occurred at **6:00P** m., from the causes and on the date stated above.

23a. SIGNATURE <b>J. C. Hendrix</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>VET ADM HOSP, JEFF BRKS, MO.</b>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>12-18-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
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DATE REC'D BY LOCAL REG. <b>12-14-52</b>	REGISTRAR'S SIGNATURE <b>Hubert R. D... M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. Waller</b> ADDRESS <b>5765 Belmont Bl.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 27 1953  
*[Handwritten signature]*

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: *Ronald A. Yelton*

Licensed Embalmer No. *2918*

P. O. Address *St. Louis*

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.