

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35438
8845

FILED OCT 26 1954

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS Mo	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN ST. LOUIS	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 2816 MAGNOLIA 24		e. STREET ADDRESS (If rural, give location) 2816 MAGNOLIA	

3. NAME OF DECEASED (Type or Print) FRED HASENPFLUG			4. DATE OF DEATH (Month) (Day) (Year) SEPT 27 1964		
a. (First)	b. (Middle)	c. (Last)	5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH FEB 17 1874	9. AGE (In years last birthday) 80	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED WATCHMAN	11. BIRTHPLACE (City and State or Foreign Country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME WILLIAM HASENPFLUG

13a. FATHER'S NAME WILLIAM HASENPFLUG	13b. MOTHER'S MAIDEN NAME ELIZABETH	14. NAME OF HUSBAND OR WIFE CAROLINE HASENPFLUG (DECD)
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 HARRY J. HASENPFLUG-6657 ADDRESS DEVONSHIRE

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUPLICATE OF (b)			
ANTECEDENT CAUSES		DUPLICATE OF (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Cerebral Hemorrhage			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 331X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on **12 NOV 1964**, from the causes and on the date stated above.

23a. SIGNATURE James M Kelly Deputy Coroner (Degree or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 9/29/54
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE Sept 30 1954	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.
24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo	25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith ADDRESS Thomas Kutis 2906 Prairie	DATE REC'D BY LOCAL REG. SEP 29 1954

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.....
Signature of Student Embalmer

Signed..... *Samuel Hill*

Licensed Embalmer No. *4347*

P. O. Address *2906 St.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.