

FILED JUN 27 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20099

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1003

State File No. ....

5241

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place) <b>12 yrs.</b>		d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <b>21 0</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Ozanam Shelter</b>		e. STREET ADDRESS (If rural, give location) <b>Ozanam Shelter Montgomery 3225</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>LOUIS</b> b. (Middle) <b>HENNEFELD</b> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <b>June 15, 1955</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	
8. DATE OF BIRTH <b>Feb. 7, 1879</b>		9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tinner (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Albert Hennefeld</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Lange</b>	
14. NAME OF HUSBAND OR WIFE <b>Never married</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	

17. INFORMANT'S SIGNATURE OR NAME <b>Miss Margaret Hennefeld</b>		ADDRESS <b>2316 Montgomery</b>	
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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) <b>Cerebral Hemorrhage</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	

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? <b>331X</b>	
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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 at 7:50 A.M., from the causes and on the date stated above.

23a. SIGNATURE <b>Deputy Registrar</b>		23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>6/17/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>June 18 '55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>4746</b>		ADDRESS <b>Bromschwig and Son W Florissant</b>	

DATE REC'D BY LOCAL REG. <b>JUN 17 1955</b>		REGISTRAR'S SIGNATURE <b>Carl Smith mo</b>		51. FUNERAL DIRECTOR'S SIGNATURE <b>4746</b>	
				ADDRESS <b>Bromschwig and Son W Florissant</b>	

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..... *W. Wilkinson*

Licensed Embalmer No. *35*

P. O. Address *M. Low*

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.