

FILED JUN 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20238

State File No. 5068

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1008** 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 town) ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place) 62 YRS.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 2109	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4223 - SACRAMENTO - AV.		STREET ADDRESS (If rural, give location) 10 4223 - SACRAMENTO - AV.	

3. NAME OF DECEASED (Type or Print)	a. (First) WILLIAM - ANTHONY -	b. (Middle) _____	c. (Last) MENKE	4. DATE OF DEATH (Month) (Day) (Year) JUNE. 9TH 1955.
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH FEB. 14TH 1874.	9. AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - PACKER	10b. KIND OF BUSINESS OR INDUSTRY ELY-WALKER-D.G.CO.	11. BIRTHPLACE (City and State or Foreign Country) GERMANTOWN - ILL. 1	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ANTHONY - MENKE.	13b. MOTHER'S MAIDEN NAME CATHERINE - GRAMANN	14. NAME OF HUSBAND OR WIFE MARY-ELIZABETH - MENKE.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO.	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE 489-01-9071	17. INFORMANT'S SIGNATURE OR NAME Mary G Menke ADDRESS 4223 SACRAMENTO
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 hour several years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. DUE TO (c) arteriosclerosis - heart disease		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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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 331X
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22. I hereby certify that I attended the deceased from **1950** to **June 9, 1955**, that I last saw the deceased alive on **June 2, 1955**, and that death occurred at **10:30 AM**, from the causes and on the date stated above.

23a. SIGNATURE Frank G. Feinberg M.D. (Degree or title)	23b. ADDRESS 462 No. Taylor	23c. DATE SIGNED 6/10/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JUNE-13TH 1955	24c. NAME OF CEMETERY OR CREMATORY CALVARY - CEMETERY.	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
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DATE REC'D BY LOCAL REG. JUN 11 1955	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Brockland Und. Co. 1827-HOGAN - ST.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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 *G. W. Wilkinson*

Licensed Embalmer No. *35*

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