

FILED AUG 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28490**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **590** Registrar's No. **1907**

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) Wellston	c. LENGTH OF STAY (in this place) 42 years	c. CITY OR TOWN Wellston	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: 1579 Ogden Avenue.		e. STREET ADDRESS (If rural, give location) 1579 Ogden Avenue.	

3. NAME OF DECEASED (Type or Print) a. (First) HELEN b. (Middle) KATHERINE c. (Last) KANNENBERG	4. DATE OF DEATH (Month) (Day) (Year) August 14, 1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Nov 2, 1881	9. AGE (In years less birthday) 73	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Peter VanDomme	13b. MOTHER'S MAIDEN NAME Emily DeFreese	14. NAME OF HUSBAND OR WIFE Henry Kannenberg
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Harry C. Kannenberg,	ADDRESS 6422 Perry Avenue.
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterial Hypertension		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage DUE TO (c) Chronic Myocarditis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertrophic Arthritis		4 days 5 years 10 years

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None	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? _____
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22. I hereby certify that I attended the deceased from **July 1, 1945**, to **Aug 14, 1955**, that I last saw the deceased alive on **Aug 14, 1955**, and that death occurred at **8 A m.**, from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title) _____	23b. ADDRESS 730 Hadzaimont St. Louis Mo	23c. DATE SIGNED 8-15-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug 17, 1955	24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri.
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DATE REC'D BY LOCAL REG. 8/16/55	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS Shepard Funeral Home, 1167 Hamilton Ave.
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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 *James Binkley*

Licensed Embalmer No. *365*

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