

FILED OCT 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34827**
Registrar's No. **9098**

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|---|--|--|--|--|--|--|--|
| 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) St. Louis | | c. LENGTH OF STAY (in this place) Life | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 2013 Madison St. | | | | e. STREET ADDRESS (If rural, give location) 20 2013 Madison St. | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) EDWARD | | b. (Middle) J. | | c. (Last) HENSIK | | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 17, 1955. | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH Sept. 5, 1875 | |
| 9. AGE (In years last birthday) 80 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Letter Carrier U.S. Post Office | | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME John M. Hensiek | | 13b. MOTHER'S MAIDEN NAME Margarette Teppe | | 14. NAME OF HUSBAND OR WIFE Flora Hensiek | | | |
| 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 ADDRESS Flora Hensiek, 2013 Madison St. | | | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute coronary occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic cardiac vascular heart disease 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 6 hrs. 8 yrs | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 42.01. | | | | 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) | | | |
| 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 8/22 , 19 55 , to 10/17 , 19 55 , that I last saw the deceased alive on 10/17 , 19 55 , and that death occurred at 12:30P m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE J. Capacent MD (Degree or title) | | | | 23b. ADDRESS 1901 Madison St | | 23c. DATE SIGNED 10/18/55 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 10/20/55. | | 24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo. | |
| DATE REC'D BY LOCAL REG. OCT 19 1955 | | REGISTRAR'S SIGNATURE J. Earl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Calvin F. Feutz, 4828 Natural Bridge Blvd. | | | |

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 *John A. Mena*
Licensed Embalmer No. *41*

P. O. Address *St. Joe*

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.