

FILED NOV 26 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39962**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **531** Registrar's No. **2600**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>University City</b>		c. CITY OR TOWN <b>University City</b>	
c. LENGTH OF STAY (in this place) <b>Life</b>		d. In 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 <b>7131 Northmoor Drive</b>		e. STREET ADDRESS (If rural, give location) <b>7131 Northmoor Drive</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Harry</b>	b. (Middle) <b>A.</b>	c. (Last) <b>Henske</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 1, 1956</b>
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5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>D.</b>	8. DATE OF BIRTH <b>Dec. 1, 1888</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Construction</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Dr. Andrew A. Henske</b>	13b. MOTHER'S M maiden NAME <b>Theresa Klaren</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Margaret Henske</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>495-28-8420</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Miss Angela E. Henske, 7131 Northmoor Dr.</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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Thrombosis of right cerebral artery</b>		<b>24 hours</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerotic Heart Disease with Calcific Aortic Stenosis</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>none</b>	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) (Min.)	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 August, 1955, to Nov, 1956, that I last saw the deceased alive on Oct. 31, 1956, and that death occurred at 12:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>J. W. Owen Jr. M.D.</b>	23b. ADDRESS <b>4952 Maryland, St. Louis, 8, Mo.</b>	23c. DATE SIGNED <b>Nov. 2, 56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Nov. 5, 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>11-2-56</b>	REGISTRAR'S SIGNATURE <b>Herbert B. Donahue</b>	GENERAL DIRECTOR'S SIGNATURE ADDRESS <b>Arthur J. Honnery 3840 Lindell Blvd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 500  
10. 68

NOV 18 1909

460-7-1109  
12 1/2 Jan

**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  .....

Licensed Embalmer No. 469

P. O. Address 3840 Lind

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.