

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43178

STATE FILE NUMBER

FILED DEC 27 1956

318

1003

Registrar's 11052

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Length of stay in lb 2-wks.	d. STREET ADDRESS 13 / 5670 Arsenal St.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Dr. Walter Middle E. Last Hennerich			4. DATE OF DEATH Month Dec. Day 3 Year 1956		
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1891	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months 5 Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Dr. Joseph Paul Hennerich			14. MOTHER'S MAIDEN NAME Anna Butze		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War # 1		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Ethel Hennerich, 5670 Arsenal St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO (b) Rheum. Hb. Disease (arterio sclerosis) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)					INTERVAL BETWEEN ONSET AND DEATH 1 month
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 411X		
20c. TIME OF INJURY Hour Month Day Year a. m. p. m. 					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Oct. 30, 1956 and last saw her alive on 12/3/56 Death occurred at 11:30 am. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) J. B. Swan MD.			22b. ADDRESS 539 N. Grand St. St. Louis		22c. DATE SIGNED 12/3/56
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 5, 1956	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis, Missouri
24. FUNERAL DIRECTOR Arthur J. Nonnelly		ADDRESS 3840 Lindell Blvd.		25. DATE RECD. BY LOCAL REG. DEC 3 1956	26. REGISTRAR'S SIGNATURE Carl Smith MD.

with, welfare, public service, 000-56, Doctor, coroner, etc. must use only standard nomenclature in Part I. No symptoms with no natural causes. diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

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..... *Francis Million*

Licensed Embalmer No. *38*

P. O. Address *384*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.