

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**59-012110**

STATE FILE NUMBER

FILED APR 15 1959

Registration District No. 362

Primary Registration District No. 6237

Registrar's No. 19

300  
1-57

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Warren</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>              |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Warrenton</u>  |  | c. CITY OR TOWN <u>Foristell R.R. 0720</u>  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Katie Jane Memorial Home</u>  |  | d. STREET ADDRESS (If outside, give location) <u>Morrion Lane</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Elihu</u> Middle <u></u> Last <u>Hennecke</u>  |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>3</u> Year <u>1959</u>  |  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 11, 1892</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Stock &amp; Grain Farm</u>   | 11. BIRTHPLACE (City and state or country) <u>Wright City, Mo.</u>                             |
| 13a. FATHER'S NAME <u>Charles Hennecke</u>   |  | 13b. MOTHER'S MAIDEN NAME <u>Ehefran Wernex</u>   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>  |  | 16. SOCIAL SECURITY NO. <u>None</u>   | 17. INFORMANT Address <u>Theophil Hennecke Augusta, Mo.</u>                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral hypostatic</u>  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Carcinoma of the stomach</u>   |  |   |  |
| DUE TO (c) <u></u>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>151X</u>  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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.)  |  |
| 20c. TIME OF INJURY<br>Hour <u></u> Month, Day, Year<br>a.m. <u></u><br>p.m. <u></u>   |  |   |  |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>Jan. 17, 1957</u> to <u>April 3, 1959</u> and last saw <u>him</u> alive on <u>April 3, 1959</u><br>Death occurred at <u>2:35 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |  |
| 22a. SIGNATURE (Doctor or title)<br><u>Theophil Hennecke</u>   |  | 22b. ADDRESS <u>Warrenton, Missouri</u>   | 22c. DATE SIGNED <u>4-9-59</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE <u>April 9, 1959</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>B. R. Cemetery</u>  | 23d. LOCATION (City, town, or county) (State) <u>Capein Missouri</u>                           |
| 24. FUNERAL DIRECTOR <u>Marie Murchay</u> ADDRESS <u>Wentzville, Mo</u>  | 25. DATE RECD. BY LOCAL REG. <u>Apr. 9, 1959</u>   | 26. REGISTRAR'S SIGNATURE <u>Helen Mildred</u>  |  |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Howard O. Kunkle* .....

Licensed Embalmer No. *4631* .....  
P. O. Address *Wentzville, Mo.* .....

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.