

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 5 4 3

FILED VS DEC 23 1959

STATE FILE NUMBER

211492

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>3251 North 19th</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>3251 North 19th</i>

3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles F. Hennicke</i>	4. DATE OF DEATH Month Day Year <i>12 - 11 - 1959</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>8-9-1889</i>	9. AGE (last birthday) <i>70</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Die Maker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Henry Hennicke</i>	13b. MOTHER'S MAIDEN NAME <i>Anna Fischer</i>	14. NAME OF HUSBAND OR WIFE <i>Kate Hennicke</i>
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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) <i>No</i>	16. SOCIAL SECURITY NO. <i>492-03-0794</i>	17. INFORMANT Address <i>Kate Hennicke - 3251 N. 19th</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Chronic Arteriosclerosis</i>	
	DUE TO (c) <i>420.1</i>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.) _____
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20c. TIME OF INJURY Hour Month, Day, Year _____

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
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21. I attended the deceased from *Jan 1958* to *Dec 11 1959* and last saw ^{him} ~~her~~ alive on *Dec 10 - 59*.
Death occurred at *1:30 A.* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>CH Jost M.D.</i>	22b. ADDRESS <i>3700 N Grand A.</i>	22c. DATE SIGNED <i>12/11/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>12-14-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cahary Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
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24. FUNERAL DIRECTOR ADDRESS <i>Edw Kochson - 3516 E. 14th</i>	25. DATE RECD. BY LOCAL REG. DEC 11 1959	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S.P.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Gustav W. Gier

Licensed Embalmer No. 4329

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.