SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-046398
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11647

FILED DEC 21 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 8 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Missouri Baptist
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: St. Louis
c. CITY OR TOWN: Hollow
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): Hencken Road
Reside on Farm: Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First: Eugene Middle: Last: Hencken
4. DATE OF DEATH: Month 12 Day 12 Year 61
5. SEX: M
6. COLOR OR RACE: W
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 3/23/1887
9. AGE (last birthday): 74
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own farm
11. BIRTHPLACE (City and state or country): St. Louis County,
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: August Krueger
13b. MOTHER'S MAIDEN NAME: Johanna Hencken
14. NAME OF HUSBAND OR WIFE: Rosamond Hencken
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
17. INFORMANT: Rosamond Hencken, Address: Pacific, Mo. Rt1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Dehydration-Hypostasis — 4 days
DUE TO (c): Severe Parkinson's Disease — 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Thrombosis Basilar artery generalized Arteriosclerosis
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 350 X
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 Dec. 2nd 1961, to 12-12-61 and last saw him alive on 12-12-61
Death occurred at 3:00 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Dominic J. Verda M.D.
22b. ADDRESS: 45000 Live St
22c. DATE SIGNED: 12-14-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE: 12/15/61
23c. NAME OF CEMETERY OR CREMATORY: Valhalla Crematory
23d. LOCATION (City, town, or county) (State): St. Charles Rock Road
24. FUNERAL DIRECTOR: Schrader Funeral Home, ADDRESS: Ballwin, Mo.
25. DATE RECD. BY LOCAL REG.: DEC 14 1961
26. REGISTRAR'S SIGNATURE: Noal Smith M.D.

DOCUMENT

BY AFFIDAVIT OF

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_____ Signed Richard Bogg

Signature of Student Embalmer

Licensed Embalmer No. 4584

P. O. Address Ballwin, M

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.