

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**62-003899**  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **567**

AMENDED

**FILED JAN 19 1962**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3321 St. Vincent</b>		d. STREET ADDRESS (If outside, give location) <b>3321 St. Vincent</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Leona E Henkel</b>			4. DATE OF DEATH Month Day Year <b>Jan. 12, 1962</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Sep 22 1898</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Philip Dietz</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Kettlegardes</b>		14. NAME OF HUSBAND OR WIFE <b>J. Henry Henkel</b>	
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>None</b>	17. INFORMANT Address <b>J. Henry Henkel 3321 St. Vincent</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cardiac Failure - Rent</b>			<b>1 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chronic cardiac degeneration</b>		<b>3 months</b>
	DUE TO (c) <b>Influenza Syndrome 481X</b>		<b>2 wks</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <b>D white mellitus</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 a.m. p.m. 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 <b>1-5-62</b> to <b>1-12-62</b> and last saw her alive on <b>1-10-62</b>	
Death occurred at <b>2:00 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <b>Philip Dietz MD</b>	22b. ADDRESS <b>3218 Lafayette</b>	22c. DATE SIGNED <b>1-12-62</b>
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23b. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Jan. 15, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Cty Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>E. J. Schnur 3125 Lafayette</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 15 1962</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF DOCUMENT 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 Joseph Wallner

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.