

WHITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

DEC 13 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

37787

State File No.

Registrar's No.

9626

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County 2
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4464 Delor St.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Henry William Tacke *H.W.T.*

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Late Annie Tacke 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 6th 1863
 (Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Quincy Illinois
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Unknown Tacke

13. Birthplace Germany
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Caroline Geoghegan

(b) Address 4464 Delor St.

17. (a) Burial (b) Date thereof 11-13-39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser Mortuar
4228 So. Kingshighway

(b) Address _____

19. (a) NOV 10 1939 (b) J. F. Bredich
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
 (c) City or town 4464 Delor St. 15
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 9th
 year 1939 hour 11:30 minute _____ P. M. _____ M.

21. I hereby certify that I attended the deceased from 6-2-39
 _____, 19____, to 11-9, 1939

that I last saw him alive on 11-9, 1939

and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Hypertrophy Duration _____

Due to Coronary Hypertension

Due to Chronic Subarterial Nephritis

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature _____ (Specify type of place) _____
 While at work? _____ (e) Means of injury _____

23. Signature J. F. Bredich (M.D. or other) _____

Address 3320 La Grand Date signed 11-10-39

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Reinhold A. Lohmann*

Licensed Embalmer No. *3395*

P. O. Address.....

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 this body is not embalmed, above space should be left blank.