DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23246

Registration District No. 791 — JUL 7 AUG 28 1941

Primary Registration District No. 1003

Registrar's No. 5598

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

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Pacific Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether

In this community 43 YRS 0 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 17 (000)

(c) City or town St Louis 29 (If outside city or town limits, write "RURAL")

(d) Street No. 5514 Goethe Ave (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Henry Joseph Delenne

3. (b) If veteran, name war None

3. (c) Social Security No. 702-12-5485

4. Sex M O

5. Color or race W

6. (a) ~~Single, widowed, married,~~ divorced 3

6. (b) Name of husband or wife MARY DELENNE

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased NOV (Month) 26 (Day) 70 (Year)

8. AGE: Years 70 Months 7 Days 9 If less than one day ___ hr. ___ min.

9. Birthplace COLLINVILLE (City, town, or county) ILL (State or foreign country) 1

10. Usual occupation Pensioner; Foreman

11. Industry or business Railroad

FATHER
12. Name JOSEPH DELENNE
13. Birthplace FRANCE (City, town, or county) (State or foreign country) 5

MOTHER
14. Maiden name MARTHA JOHNSON
15. Birthplace COLLINVILLE (City, town, or county) ILL (State or foreign country) 1

16. (a) Informant MRS DAISY KINKADE

(b) Address 5514 GOETHE AVE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7 (Month) 8 (Day) 41 (Year)

(c) Place: burial or cremation Collinsville Illinois

18. (a) Signature of funeral director KRIESSHAUSER UND Co

(b) Address 4228 SO. KINGHIGHWAY BLVD

19. (a) JUL 7 1941 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6 year 1941 hour 8 minute 15 PM M.

21. I hereby certify that I attended the deceased from July 3, 1941 to July 6, 1941 that I last saw him alive on July 6, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Left Lobar Pneumonia	8 days
Due to	
Due to	
Other conditions Bronchial Asthma (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Royal A. Weir (M. D. ~~or other~~)

Address 1755 So Grand Date signed 7/6/41

(Licensed Embalmer's Statement on Reverse Side)

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 Edwin A M Dermott

Licensed Embalmer No. 3024

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23246

Registration District No. 191 Primary Registration District No. 1003 Registrar's No. 5598

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

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Henry J. Delenne
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

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

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 9-16-41 (Date received local registrar) (b) J. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 6 day
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY