

State File No. ....

Registration District No. 206

Primary Registration District No. 6048

Registrar's No. 251

1. PLACE OF DEATH:  
 (a) County ST. CHARLES  
 (b) City or town O'FALLON  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (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

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

3. (a) PRINT FULL NAME ALBINA HENKE  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w  
 6. (a) Single, widowed, married, divorced 1  
 6. (b) Name of husband or wife DAVID HENKE  
 6. (c) Age of husband or wife if alive 60 years  
 7. Birth date of deceased MAY 15 1887  
 (Month) (Day) (Year)

8. AGE: Years 58 Months 5 Days 5  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace LAZDENNE Mo  
 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name BECKER  
 13. Birthplace GERMANY 4  
 (City, town, or county) (State or foreign country)

14. Maiden name AMTMBY  
 15. Birthplace ST. CHARLES Co. Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant David Henke  
 (b) Address O'Fallon Mo

17. (a) Burial (b) Date thereof Oct 24 45  
 (Burial, cremation, or otherwise) (Month) (Day) (Year)  
 (c) Place: burial or cremation O'Fallon Mo

18. (a) Signature of funeral director E. A. Keethly  
 (b) Address O'Fallon Mo

19. (a) Oct 29 - 45 (b) E. A. Keethly  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Oct day 20  
 year 1945 hour 30 minute 0 P. M.  
 21. I hereby certify that I attended the deceased from June 19 44 to Oct 20 45  
 that I last saw him alive on Oct 19 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia (Hypostatic)  
 Due to Multiple Sclerosis  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 Means of injury \_\_\_\_\_  
 23. Signature M. J. Honick MO (M. B. Registrar)  
 Address O'Fallon, Mo. Date signed 10/22/45

Duration 4 days  
vym.  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed

11-5-45

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.....

*E. Keithly*

Licensed Embalmer No.....

872

P. O. Address.....

*Fallan Mo*

**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, fact should be so stated above.**