

FILED APR 18 1946

Registration District No. 318

Primary Registration District No. 1003

State File No.

Registrar's No. 3044

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
5512 Minnsota
 (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 V Thake

3. (b) If veteran, name war No 3. (c) Social Security No

4. Sex Male 5. Color White 6. (a) Single Married
 divorced _____
 6. (b) Name of husband or wife Nellie Thake 6. (c) Age of husband or wife if
 alive 54 years
 7. Birth date of deceased D66 15 1878
 (Month) (Day) (Year)

8. AGE: Years 67 Months 3 Days 15 If less than one day
 hr. _____ min. _____

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

10. Usual occupation none

11. Industry or business _____

12. Name Wm. Thake
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Katherine Branger
Germany
 (City, town, or county) (State or foreign country)
 15. Birthplace _____

16. (a) Informant Mrs Henry Thake
 (b) Address 5512 Minnsota

17. (a) burial (b) Date thereof 4/2/46
 (Burial, cremation, or removal) (Month) (Day) (Year)
S S Peter Paul

(c) Place: burial or cremation _____

18. (a) Signature of funeral director FENDLER UND CO

(b) Address 7420 Michigan Ave

19. (a) APP 1 1946 (b) J. F. Budrick
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5512 Minn. Ave
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30th
 year 1946 hour 3:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from Dec 43 to 30 Mar 46
 that I last saw him alive on 30 March and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage.

Due to Hypertensive Cardio-vascular disease unknown

Due to _____

Other conditions none
 (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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 D

23. Signature Charles A Nester (M. D. or other)

Address 439 Bates Date signed 1 Apr 46

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

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..... *Oliver E. Fendler*
Licensed Embalmer No. *4448*
P. O. Address *623 Pearl Blvd*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 384x

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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 D. Thake

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.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 67 Months 3 Days..... (less than one day) hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

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) 4-1-1946 (b) J F Budeck (Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Year 1946 Hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

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)

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

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

25. Signature..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

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

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