

FILED APR 19 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

12518

State Eric No.

Registrar's No. 14

BIRTH NO. _____		REG. DIST. NO. 114		PRIMARY REG. DIST. NO. 213	
1. PLACE OF DEATH a. COUNTY FRANKLIN			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL - TOWNSHIP NEW 7 MONTHS			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Manchester, Mo. 4000		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Miller Home for Aged			d. STREET ADDRESS (If rural, give location) Woodsmill Rd.		
3. NAME OF DECEASED (Type or Print) a. (First) Henry		b. (Middle) _____		c. (Last) Engelke	
4. DATE OF DEATH (Month) (Day) (Year) Apr. 5, 1950		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED		8. DATE OF BIRTH June 19, 1870		9. AGE (In years last birthday) 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Ellisville, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Herman Engelke		13b. MOTHER'S MAIDEN NAME Ann Brown	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Al Du Parri, Manchester, Mo.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		MEDICAL CERTIFICATION ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio sclerosis		DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from March 14, 1950 , to 4-5-1950 , that I last saw the deceased alive on 3/21 , 1950, and that death occurred at 3:50 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Chas. E. Prater M.D.		23b. ADDRESS Sullivan, Mo.		23c. DATE SIGNED 4/5/1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-8-1950		24c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH	
24d. LOCATION (City, town, or county) (State) MANCHESTER, Mo.		DATE REC'D BY LOCAL REG. 4-5-1950		REGISTRAR'S SIGNATURE Chas. E. Prater	
25. FUNERAL DIRECTOR'S SIGNATURE Schrader Funeral Home, Ballwin, Mo.		ADDRESS _____			

03605

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

District File Number _____
District Health Officer No. 9
RECEIVED
APR 11 1950

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.
Thos. Schradew
Signed.....
Licensed Embalmer No. *3066*
P. O. Address *Baltimore, 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.