

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34804

State File No. \_\_\_\_\_

FILED OCT 26 1949

BIRTH NO. _____		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. <u>183</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Charles</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. LENGTH OF STAY (in this place) <u>24 hrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>O'Fallon</u>		720	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph HOSPITAL.</u>				d. STREET ADDRESS (If rural, give location) <u>01</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Leo</u>		b. (Middle) <u>J.</u>		c. (Last) <u>Henke</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>3</u> (Year) <u>8 49</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>		8. DATE OF BIRTH <u>Jan. 11 1903</u>		9. AGE (In years last birthday) <u>46</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>O'Fallon Rural Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US A</u>	
13a. FATHER'S NAME <u>Marcus Henke</u>		13b. MOTHER'S MAIDEN NAME <u>Hemmer</u>		14. NAME OF HUSBAND OR WIFE <u>Marion married deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Simon Henke O'Fallon Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>uremia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>chr nephritis</u> DUE TO (c) <u>592X</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>cardiomyopathy chr.</u> <u>4 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1947</u> , to <u>10-3</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>10-2</u> , 19 <u>49</u> , and that death occurred at <u>8:30</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Laurence G. Behan MD</u>				23b. ADDRESS <u>O'Fallon Mo</u>		23c. DATE SIGNED <u>10-7-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 5 '49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Dardenne</u>		24d. LOCATION (City, town, or county) (State) <u>O'Fallon Rural Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-16-49</u>		REGISTRAR'S SIGNATURE <u>Laurence G. Behan</u>		FUNDING DIRECTOR'S SIGNATURE <u>Laurence G. Behan</u>		ADDRESS <u>O'Fallon Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
OCT 22 1949  
District Health Officer No.  
District File Number

NOV 8 1949

### 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*E. Keith*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 822

P. O. Address O'Fallon 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.