

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10877

Registration District No. 107 Primary Registration District No. 4178 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town St. Louis Mo  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Zena Palmer Henderson  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. L

4. Sex 2 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Russell Henderson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 8 1899  
(Month) (Day) (Year)

8. AGE: Years 41 Months 3 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name Zelata Skinner  
13. Birthplace New Hope, Ill.  
(City, town, or county) (State or foreign country)

14. Maiden name Marion Taylor  
15. Birthplace Equality, Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Allen Clippard  
(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 4-2-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Equality, Ill.

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) April 9, 40 (b) H. P. Duckworth  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Jackson  
(c) City or town St. Louis Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 31  
year 1940 hour 8:30 minute \_\_\_\_\_ A. M.  
21. I hereby certify that I attended the deceased from Jan 1937 to March 31 1940  
that I last saw her alive on March 31 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Primary T. B. Duration 4 yrs.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions 1/2  
(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)  
(e) Means of injury \_\_\_\_\_

23. Signature H. P. Duckworth (M. D. or other) \_\_\_\_\_  
Address St. Louis Mo Date signed 3/24/40

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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**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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *Albert Embalmer*

Licensed Embalmer No. 1994

P. O. Address St. Louis, 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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10875  
Registrar's No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 294

Primary Registration District No. 4178

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

**1. PLACE OF DEATH:**  
 (a) County St. Francois  
 (b) City or town St. Clair  
 (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..... (Specify whether  
 years, months or days)

**3. (a) PRINT FULL NAME:** Zula Palmer Henderson  
**3. (b) If veteran, name war.....** **3. (c) Social Security No.....**

**4. Sex:** 7 **5. Color or race:** W **6. (a) Single, widowed, married, divorced:** wid  
**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 41 Months 3 Days 13 If less than one day, hr. min.

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

**10. Usual occupation.....**

**11. Industry or business.....**

**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) (Date received local registrar)..... (b) (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) If foreign born, how long in U. S. A.?..... years

**20. DATE OF DEATH:** Month Mar day 31 year..... hour..... minute..... M.  
**21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on..... and that death occurred on the date and hour stated above.**

**Immediate cause of death.....**  
 Due to.....  
 Due to.....  
 Other conditions..... (Include pregnancy within 3 months of death)  
**Major findings:**  
 Of operations.....  
 Of autopsy.....

**Duration**  
  
  
  
  
  
  
  
  
  
**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.....  
**23. Signature:** W. H. Duckworth (M.D. or other).....  
 Address: St. Clair Date signed.....

SUPPLEMENTAL

5-10877  
1940