

V. S. No. 2  
OM-94-41  
Rev. 5-17-39  
I X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

16999  
2022

State File No.

FILED JUN 6 1942

Registration District No.

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4516 E 20th  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community 28 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4516 E. 20th St.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Lillian Henke

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Henke 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased February 12 1880  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>3</u>	<u>12</u>	hr. min.

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

10. Usual occupation House wife

11. Industry or business Same

12. Name Peter Fitzpatrick Fitzpatrick

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

14. Maiden name Henke

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

16. (a) Informant Mr. William Henke

(b) Address 4516 E. 20th St.

17. (a) Burial (b) Date thereof 5 / 26 / 42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Rose & Henderson  
(b) Address 4139 E. 15th St.

19. (a) 5-25-42 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24  
year 1942 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from 1935  
19..... to 5/24 1942  
that I last saw h. or alive on 5/23 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death cardiac decompensation heart block

Due to myocarditis 5 yrs.

Due to hepatitis. Ch. 3 yrs.

Other conditions (Include pregnancy within 3 months of death) 131P

Major findings: Of operations.....  
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?

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

23. Signature H. D. [unclear] (M. D. or other) 0  
Address 700 Apple Bay, N.C. 700 Date signed 5/25/42

(Licensed Embalmer's Statement on Reverse Side)

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

48  
83

48  
5  
8  
0

MOTHER FATHER

561

*Dr Townsend  
Aurora, Ill.*

JUN 8 1944

**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

*John B. Camp*

Licensed Embalmer No. *2955*

P. O. Address *1100*

**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.**