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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 2 - 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30918

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 8524

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days (Specify whether years, months or days)
In this community 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")

(d) Street No. 4448 W. Belle
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Henderson

3. (b) If veteran, name war ---

3. (c) Social Security No. 702-14-1332

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Emma A. Henderson

6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased Unavailable (Month) 1879 (Year)

8. AGE: Years Abt. 64 | Months -- | Days -- | If less than one day -- hr. -- min.

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

10. Usual occupation Cook

11. Industry or business Missouri Pacific R. R.

MOTHER FATHER

12. Name Unavailable

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

MOTHER

14. Maiden name Unavailable

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

16. (a) Informant Emma Ashby Henderson

(b) Address 4448 West Belle Place

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/43 (Month) (Day) (Year)

(c) Place: burial or cremation Wash Greenwood Cem.

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Avenue

19. (a) SEP 27 1943 (Date received local reg.) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 23, year 1943 hour 2 minute 09 P. M.

21. I hereby certify that I attended the deceased from September 11, 1943 to September 23, 1943 that I last saw him alive on September 23, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Prob. Carcinoma of Stomach with Hemorrhage; Secondary Anemia	Unk.
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature S. E. Smith (M. D.)

Address 260 Wheeler Date signed 9/24/43

(Licensed Embalmer's Statement on Reverse Side)

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

Thomas J. Gates, Registered Apprentice No.

working under my personal supervision.

Signed Thomas J Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.