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FILED JAN 20 1944

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1791**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
(b) City or town
(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 **4 days**
(Specify whether
In this community **60 years**
years, months or days)

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. **4239 W. Cozens**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Cora Henderson**

3. (b) If veteran, name war **---** 3. (c) Social Security **492-16-9033**

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Henry Henderson** 6. (c) Age of husband or wife if alive **--** years

7. Birth date of deceased **July 16, 1867**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 5 18 --hr. --min.

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

10. Usual occupation **Housewife**

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

12. Name **Pat Mimms**

13. Birthplace **Clarksville Tennessee**
(City, town, or county) (State or foreign country)

14. Maiden name **Unavailable**

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

16. (a) Informant **Wilkins Getter**
(b) Address **4239 Cozens**

17. (a) **Burial** (b) Date thereof **1/8/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park Cem.**

18. (a) Signature of funeral director **Charles J. Gates**
(b) Address **4107 Finney Avenue**

19. (a) **JAN 7 1944** (Date received local registrar) **J. F. Brueck** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **4**,
year **1944** hour **6** minute **00** P. M.
December

21. I hereby certify that I attended the deceased from **31, 1943** to **January 4, 1944**
that I last saw h. er alive on **January 4, 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerotic Heart Disease** Duration **Unk.**
Chr. Nephritis **Unk.**

Due to
Due to
Other conditions (Include pregnancy within 3 months of death) **1/3/1**

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?

While at work? (Specify type of place) (e) Means of injury
23. Signature **S. E. Smith** (M. D. or other) **0**
Address **2001 W. 11th** Date signed **1/6/44**

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

3003-01-134

7882

31 1960

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.....



.....
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.