

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5397

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Mo.  
 (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) 0  
 (d) Length of stay: In hospital or institution 3 days  
 In this community 20 years  
 years, months or days (Specify whether)

3. (a) PRINT  
FULL NAME

Robert Henderson

3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. 718-07-64742  
4. Sex Male5. Color or  
race Negro6. (a) Single, widowed, married,  
divorced. Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased February  
(Month)1864  
(Day) (Year)

## 8. AGE:

Years

Months

Days

If less than one day

80

4

hr. min.

9. Birthplace Charlotte, North Carolina  
(City, town, or county) (State or foreign country)

10. Usual occupation

Labor

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

12. Name Unknown13. Birthplace Unknown  
(City, town, or county) (State or foreign country)14. Maiden name Angeline Henderson15. Birthplace Richmond, Virginia  
(City, town, or county) (State or foreign country)16. (a) Informant Joseph Saville(b) Address 4566 Aldine Avenue17. (a) Interment (b) Date thereof 6-16-44  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Washington Park18. (a) Signature of funeral director Boyd Bros Undertaking(b) Address 3704 Finney Avenue19. (a) JUN 15 1944 (b) J. F. Brudick  
(Date received local registrar) (Registrar's signature)

## 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. 4566 Aldine  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12,  
 year 1944 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from June  
9, 1944, to June 12, 1944  
 that I last saw him alive on June 12, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death

Arteriosclerotic Cardio-Vascular  
disease

Duration

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 sta-  
tistically.

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 Alvina Rose (M. D. or other)Address 3621 N. Skitter Date signed 6/14/44

**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.....  
*William E. McDowell*, Registered Apprentice No.....  
working under my personal supervision.

Signed.....*William E. McDowell*.....

Licensed Embalmer No.....*3114*.....

P. O.-Address.....

**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.**