V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

FILED NOV 2 1945

State File No. 31963

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9256

**1. PLACE OF DEATH:**

(a) County

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

(c) Name of hospital or institution: ALEXIAN BRO. Hosptl (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mo (Specify whether

In this community Life years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County St Louis 96

(c) City or town Lemay (If outside city or town limits, write "RURAL")

(d) Street No. 822 ~~Eugenia~~ Reginao (If rural, give location)

(e) Citizen of foreign country? — (Yes or No) N.B.

If yes, name country —

3. (a) PRINT FULL NAME Charles J. Henson

3. (b) If veteran, name war

3. (c) Social Security No. 497-03-1356

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Atrall Henson

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

7. Birth date of deceased Nov (Month) 5 (Day) 1900 (Year)

8. AGE: Years 44 Months 11 Days 19 If less than one day hr. min.

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

10. Usual occupation Order Filler

11. Industry or business Ely Walker Dry Goods Co

FATHER
12. Name Albert Henson
13. Birthplace (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Sarah Edsell
15. Birthplace (City, town, or county) Mo (State or foreign country)

16. (a) Informant Atrall Henson

(b) Address 822 Eugenia

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-45 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director Fred M. Wiesian

(b) Address 4535 Washington

19. (a) OCT 26 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month October day 24 year 1945 hour 3:00 minute P. M.

21. I hereby certify that I attended the deceased from July 24, 1945, to October 24, 1945 that I last saw him alive on October 24, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death General Carcinomatosis | 3 mo |
| Due to Carcinoma of left lung | 6 mo |
| 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 [illegible] (M. D. or other)

Address 7702 Lemay Date signed 10/26/45

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Jay W Wilkinson

Licensed Embalmer No. 3575

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.**