

FILED DEC 7 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10274

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
Barnard Skin & Cancer Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME William S. Henderson

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Molly

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

7. Birth date of deceased Jan. 16 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

78	10	10	hr. _____ min.
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9. Birthplace Pike Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

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

12. Name Joseph Henderson

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

14. Maiden name Catherine Anderson

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

16. (a) Informant Ralph Ware

(b) Address 4815 Cupples Pl.

17. (a) Burial (b) Date thereof 11-29-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bowling Green, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) NOV 27 1945 (Date received local registrar)

J. F. Bredecker (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike 82

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

(d) Street No. \_\_\_\_\_ (If rural, give location) NR

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26  
year 1945 hour 8 minute 2 M.

21. I hereby certify that I attended the deceased from 11-15-45  
19\_\_\_\_ to 11-26-45 19\_\_\_\_

that I last saw him alive on 11-20-45 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death LARYNGEAL EDEMA  
Duration 30 min.

Due to Post-operative 6 days

Due to SQUAMOUS CARCINOMA  
RT. SIDE OF NECK

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations AS ABOVE

Of autopsy NOT PERFORMED

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)

Means of injury \_\_\_\_\_

23. Signature Charles H. Herwin (M. D.)

Address 3720 Washington Date signed 11/27/45

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

MOTHER FATHER

**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 Elmo R Cadwell  
Licensed Embalmer No. 4077  
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.**