

FILED DEC 7 1945
318
Registration District No.

Primary Registration District No. 1003

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: Exposante to City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 (Specify whether 3 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 4119 Magnolia Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Vernor E. Henshie

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Dec. 19, 1880
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>64</u>	<u>11</u>	<u>1</u>	_____ hr. _____ min.

9. Birthplace Blue Mound Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Organist

11. Industry or business _____

12. Name Samuel Henshie

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

14. Maiden name Carrie Edison

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

16. (a) Informant Arthur Webb

(b) Address Lebanon Illinois

17. (a) Removal-Motor (Burial, cremation, or removal) (b) Date thereof Nov. 23/45
(Month) (Day) (Year)

(c) Place: burial or cremation Blue Mound, Illinois

18. (a) Signature of funeral director Weick Bros.

(b) Address 2201 S. Grand Bl.

19. (a) NOV 21 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20 year 1945 hour 11 minute 40 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above

Immediate cause of death Sublethal hemorrhage due to stab wound self-inflicted with knife in Tower Grove Park

Due to Nov. 20 1945 about 11:40 P.M.

Due to _____

Other conditions 164
(Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide suicide

(b) Date of occurrence Nov 20 1945

(c) Where did injury occur? Public Park
(City or town) (County) (State)

(d) Did injury occur in or about home, or farm, in industrial place, in public place?
(Specify type of place) (e) Means of injury as above

23. Signature Patricia E. Taylor (M.D. or other) 3

Address Deputy Coroner Date signed 11.21.45

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

1859

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

Sam A. Dewael

Licensed Embalmer No. 3722

P. O. Address. 412 Duchouquette St.

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.