

FILED JAN 19 1947

318

Primary Registration District No. _____

1003

Registration District No. _____

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: **St. Louis City Hospital - Max C. Starkloff**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **WILLIAM HENDERSON**

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

4. Sex **MO** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased **January - 30 - 19**
(Month) (Day) (Year)

8. AGE: Years **abt 57** Months **-** Days **-** If less than one day _____
hr. _____ min.

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

10. Usual occupation **Railroad mtr**

11. Industry or business _____

12. Name **George Henderson**

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

14. Maiden name **Mary** - **Unknown**

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

16. (a) Informant **M. Ramsey**

(b) Address **Anatomical Board City Hospital**

17. (a) _____ (b) Date thereof **12-9-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis, Mo.**

18. (a) Signature of funeral director **W. Richter**

(b) Address **5500 Kater**

19. (a) **DEC 31 1946** **J. F. Breda**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St Louis**
(c) City or town **St Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1124**
Memorial (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION:

20. DATE OF DEATH: Month **Dec.** day **1st**
year **1946** hour **11:30** minute **A** M.

21. I hereby certify that I attended the deceased from **11/11/46**
to **Dec. 1st 1946**
that I last saw him alive on **Dec. 1st 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cor Pulmonale** Duration **2 Mos.**

Due to **Asthma** **? years**

Due to _____

Other conditions **1/2**
(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:

(c) 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) (a) Means of injury _____

23. Signature **J. F. Breda** **12/2/46**
1515 Lafayette (Other) _____

Address _____ Date signed _____

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.....

Licensed Embalmer No.....

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.