

Registration District No. 149

Primary Registration District No. 1002

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution:  
7611 Wornall Rd /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 20 years. (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State ## Kansas (b) County Johnson 999

(c) City or town Overland Park 14  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) 2  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Bud Henderson

3. (b) If veteran, name war No

3. (c) Social Security No. No

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month March day 12  
year 1947 hour 5 minute 10P M.

4. Sex Male

5. Color or race Wh

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased Jan. 9 1859  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11 46 3/12 1947

that I last saw him alive on 3/9/47 19\_\_\_\_; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>2</u>	<u>3</u>	hr. _____ min. _____

Immediate cause of death Arteriosclerosis  
Obliterans with  
Angiome, less lower  
extremities. Duration 60 days

9. Birthplace Logan Co. Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Plumbing Retired 20 Yrs.

Due to Above

Due to None

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

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

12. Name Washington Henderson

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

14. Maiden name Elizabeth Sawyer

15. Birthplace No Record  
(City, town, or county) (State or foreign country) 9

Major findings: Of operation None 97

Of autopsy None

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Nellie Henderson

(b) Address 8444 Wornall

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 14 1947  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cem

18. (a) Signature of funeral director Wornall Funeral Home

(b) Address 7406 Wornall

19. (a) 3-13-47 (Date received local registrar) (b) Seraldine Holmer (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) NO-

(b) Date of occurrence \_\_\_\_\_

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? 0

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature William B. Allen M.D. (M. D. or other) 3/13/47

Address Professional Bldg Kansas City Mo

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

MOTHER FATHER

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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.....

*Howard J. Roe*

Licensed Embalmer No.....

*2748*

P. O. Address.....

*K. C. Mo*

**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.**