

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24881  
Registrar's No. 6112

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO		b. COUNTY DU	
b. CITY OR TOWN St Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1327 N. Sarah		d. STREET ADDRESS 17-1327 N. SARAH			

3. NAME OF DECEASED a. (First) Rom			b. (Middle) L. E.			c. (Last) Hendricks			4. DATE OF DEATH (Month) (Day) (Year) July 7, 1949		
5. SEX M. D		6. COLOR OR RACE N.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH Nov 4, 1883		9. AGE (In years, last birthday) 66		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Mo. D		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME Roy Hendricks			13b. MOTHER'S MAIDEN NAME Anna Stewart			14. NAME OF HUSBAND OR WIFE Mary Belle					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 494-05-0858			17. INFORMANT'S SIGNATURE OR NAME Mary Belle Hendricks			ADDRESS 1327 N. Sarah		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</u>		DUPLICATE OF (b) <u>Hypertension (Chronic)</u>							
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (c) _____							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? FELL			

22. I hereby certify that I attended the deceased from 6/15/1949, to 7/9/1949, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 4 P.M., from the causes and on the date stated above.

23a. SIGNATURE Dr. Wm E. Hines, M.D.		(Degree or title)		23b. ADDRESS 4421 E. Easton		23c. DATE SIGNED 7/11/49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 7/14/49		24c. NAME OF CEMETERY OR CREMATORY Washington		24d. LOCATION (City, town, or county) (State) Centerville Twp. Ill.	

DATE REC'D BY LOCAL REG. JUL 13 1949		REGISTRAR'S SIGNATURE J. B. Baseler		25. FUNERAL DIRECTOR'S SIGNATURE R.M.C. Green		ADDRESS 2517 W. 60th St. E. St. P.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Melvin E. Green

Licensed Embalmer No. 4428

P. O. Address St. Louis, 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.