

FILED DEC 6 1949

STANDARD CERTIFICATE OF DEATH

State File No. 39743
04507

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pulaski	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Jefferson Barracks, Mo.)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richland	
c. LENGTH OF STAY (in this place) 115 days		d. STREET ADDRESS (If rural, give location) ---	
d. FULL NAME OF HOSPITAL OR INSTITUTION Vet. Adm. Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) H. c. (Last) HENSON		4. DATE OF DEATH (Month) (Day) (Year) Nov. 23, 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 2-16-88
9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber	11. BIRTHPLACE (State or foreign country) Pulaski County, Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME George Henson	13b. MOTHER'S MAIDEN NAME Mary Holdron	14. NAME OF HUSBAND OR WIFE ----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) World War I	16. SOCIAL SECURITY NO. Unknown
17. INFORMANT'S SIGNATURE OR NAME VA Hospital Records		ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Unknown
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) GENERALIZED CARCINOMATOSIS		
	ANTECEDENT CAUSES DUE TO (b) Adeno Carcinoma of Kidney <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			180X
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 180X		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug. 1, 1949**, to **Nov. 23, 1949**, and that death occurred at **10:20 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE L.E. Stilwell (Degree or title) L.E. Stilwell, M.D. - Chf. Prof. Services	23b. ADDRESS Vet. Adm. Hosp. Jeff. Brks. Mo.	23c. DATE SIGNED 11/25/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Nov 26 1949	24c. NAME OF CEMETERY OR CREMATORY Richland, Missouri	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 11-25-49	REGISTRAR'S SIGNATURE Herbert W. Donke	25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister	ADDRESS U&L Co., St. Louis, Mo.
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Harold J. Shumaker*

Licensed Embalmer No. 2679

P. O. Address 781 1/2 S. Broadway

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.