

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6310

State File No.

BIRTH NO. 10754-50 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1988

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>(Home) 2914 Dickson St</u>		d. STREET ADDRESS (If rural, give location) <u>2914 Dickson St</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Sandra</u>	b. (Middle)	c. (Last) <u>Henry</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3 1 1950</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Baby 0</u>	8. DATE OF BIRTH <u>1-23-1950</u>
9. AGE (In years last birthday) <u>5 weeks</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HR. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>St. Louis MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>William B. Henry</u>	13b. MOTHER'S MAIDEN NAME <u>Mertie Graham</u>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mertie Henry 2914 Dickson St</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Brauchs Pneumonia</u>		
	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 checked="" 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) <u>491X</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:19 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Patrick E. Taylor Col.</u>	23b. ADDRESS <u>1300 Clark</u>	23c. DATE SIGNED <u>3-1-50.</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>3-2-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Green Wood Cemetery</u>
24d. LOCATION (City, town, or county) (State) <u>MO</u>		

DATE REC'D BY LOCAL <u>MAR 1 1950</u>	REGISTRAR'S SIGNATURE <u>J. B. Luster</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gus Lowe 2930 Dickson St</u>
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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 Arthur L. Helliard

Licensed Embalmer No. 4221

P. O. Address 4049 St Ferdinand

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.