

FILED JAN 5 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41643
5487

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (In this place) 65 yrs		d. STREET ADDRESS (If rural, give location) 6143 Forest	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Menorah Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) MINNIE	b. (Middle) M.	c. (Last) HENKER	4. DATE OF DEATH (Month) (Day) (Year) 12 18 51
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5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1-13-1865	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Saxony, Germany	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Albert Rosel	13b. MOTHER'S MAIDEN NAME Caroline Lehman	14. NAME OF HUSBAND OR WIFE Robert Henker
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. XX	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mattie Strange, 3616 Anderson
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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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Insufficiency and Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of gall bladder with metastasis DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 6 weeks
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension		155x

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Nov 3, 1951**, to **Dec 18, 1951**, that I last saw the deceased alive on **Dec 17, 1951**, and that death occurred at **3:55 Am.**, from the causes and on the date stated above.

23a. SIGNATURE S. D. Hooper, M.D.	23b. ADDRESS 6232 Troost K.C. Mo	23c. DATE SIGNED Dec 19, '51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-20-51	24c. NAME OF CEMETERY OR CREMATORY Forest Hill	24d. LOCATION (City, town, or county) (State) Kansas City Mo.
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DATE REC'D BY LOCAL REG. 12-21-51	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. M. Wagner, K C Mo.
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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 *Alvin R. Haenschell*

Licensed Embalmer No. *4159*

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.