

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15792**
4164

FILED MAY 14 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 2yr 9mo 2dy	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary		e. STREET ADDRESS (If rural, give location) 13 5800 Arsenal St	
3. NAME OF DECEASED a. (First) ELIZABETH (Type or Print) Lizzie	b. (Middle)	c. (Last) Henson	4. DATE OF DEATH (Month) (Day) (Year) April 20, 1953
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) separated	8. DATE OF BIRTH July-15-1904
9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months 9	IF UNDER 1 YEAR Days 5	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Leachville, Arkansas
12. CITIZEN OF WHAT COUNTRY?	13a. FATHER'S NAME Joseph Maddox	13b. MOTHER'S MAIDEN NAME Myrtle ??? Lewis	14. NAME OF HUSBAND OR WIFE Henson 1 Auddie Mandrell 2 Floyd
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Max Schetter Linn, Mo	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Central Nervous System Lues		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) with Brain Damage		DUE TO (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 checked="" 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)	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? 023X		
22. I hereby certify that I attended the deceased from June 27, 1950 , to April 20, 1953 , that I last saw the deceased alive on April 20, 1953 , and that death occurred at 6:10 Pm. , from the causes and on the date stated above.			
22a. SIGNATURE (Degree or title) Blair Duane Bowlich M.D.		23b. ADDRESS 5800 Arsenal St.	23c. DATE SIGNED 4-21-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/23/53	24c. NAME OF CEMETERY OR CREMATORY Malden Cemetery	24d. LOCATION (City, town, or county) (State) Malden Mo
DATE REC'D BY LOCAL REG. APR 22 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Clayde Morton - Linn, Mo	

MAY 14 1952

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.....
Signature of Student Embalmer

Signed *Vernon M. Morten*.....

Licensed Embalmer No. *425*.....

P. O. Address *Linn 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.