

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39645

State File No. \_\_\_\_\_

X No. 300  
v. 10.48

DEC 1 - 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 179 PRIMARY REG. DIST. NO. 5667 Registrar's No. 70

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Troy</u>	c. LENGTH OF STAY (in this place) <u>24 hrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>O'Fallon</u> <u>0920</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lincoln Co. Hospital</u>		d. STREET ADDRESS (If rural, give location) -----	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Gladys</u> b. (Middle) <u>Rose</u> c. (Last) <u>Henke</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 22 1953</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, <u>WIDOWED</u> , DIVORCED (Specify)	8. DATE OF BIRTH <u>Mar. 20 1932</u>	9. AGE (In years last birthday) <u>21</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>office worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Wagoner Electric</u>	11. BIRTHPLACE (State or foreign country) <u>O'Fallon, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Simon Henke</u>	13b. MOTHER'S MAIDEN NAME <u>Bauer</u>	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>496-34-8100</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Simon Henke</u>	ADDRESS <u>O'Fallon Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>(1) Fractured Skull</u> <u>(2) Compound comminuted fracture of right leg.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Auto accident</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>E8164</u> <u>26</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE HOMICIDE <u>accident highway</u>	21b. PLACE OF INJURY (e.g., in or about home, hotel, factory, street, office bldg., etc.) <u>highway 61-</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) <u>O'Fallon</u> (STATE) <u>MO</u> <u>4 miles north of Troy Lincoln Co - MO</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>11 20 53 3:22</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Auto accident - Collision</u>
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22. I hereby certify that I attended the deceased from 11/21, 1953, to 8:15 PM: 11/22, that I last saw the deceased alive on 11/22, 1953, and that death occurred at 8:15 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. C. Creech M.D.</u>	23b. ADDRESS <u>1 Roy, 2020</u>	23c. DATE SIGNED <u>11/22/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 26 '53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Assumption</u>	24d. LOCATION (City, town, or county) (State) <u>O'Fallon Mo.</u>
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DATE REC'D BY LOCAL REG. <u>DEC 1 1953</u>	REGISTRAR'S SIGNATURE <u>Clayde A. Bridges</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. Keithly</u>	ADDRESS <u>O'Fallon Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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REC 1 1936

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 E. Keithly

Licensed Embalmer No. 877

P. O. Address Fallon 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.