

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24666

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5987**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri. b. COUNTY									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis, Mo.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 3850 Washington.				e. STREET ADDRESS (If rural, give location) 3850 Washington.									
3. NAME OF DECEASED (Type or Print) a. (First) John			b. (Middle) H.		c. (Last) Henry		4. DATE OF DEATH (Month) (Day) (Year) June 30, 1954						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb. 2, 1880		9. AGE (In years last birthday) 74		10. UNDER 1 YEAR Months		11. UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof Reader				10b. KIND OF BUSINESS OR INDUSTRY News paper				11. BIRTHPLACE (City and State or Foreign Country) South Carrollton Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME John Henry			13b. MOTHER'S MAIDEN NAME Amanda Riley			14. NAME OF HUSBAND OR WIFE Mary E. Henry							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.			16. SOCIAL SECURITY NO. Nil.			17. INFORMANT'S SIGNATURE OR NAME Mary E. Henry, 3838a Olive. St.			ADDRESS				
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 1 week					
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertention				DUE TO (c) Endocarditis				4 years					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								10 years					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input 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)							
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? 331x							
22. I hereby certify that I attended the deceased from June 15, 1954 to June 30, 1954 , that I last saw the deceased at 8 P.M. , and that death occurred at 8 P.M. , from the causes and on the date stated above.													
23a. SIGNATURE Dorothy Dahms M.D.						23b. ADDRESS 1452 S. Grand			23c. DATE SIGNED 7-2-54				
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal			24b. DATE 7-3-54		24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery			24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.					
DATE REC'D BY LOCAL REG. JUL 2 1954			REGISTRAR'S SIGNATURE Carl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe			ADDRESS 4700 Washington.				

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *John J. Haines*.....
Licensed Embalmer No. *410*.....
P. O. Address: *Albany*.....

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.