

FILED DEC 9 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 38018

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

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>359</u>	
1. PLACE OF DEATH <b>MILLERS REST HOME</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY <b>MARION</b>		a. STATE <b>Mo</b>		b. COUNTY <b>MARION</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>HANNIBAL</b>		c. LENGTH OF STAY (in this place) <b>2 Wks.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>HANNIBAL</b>		0644 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Millers Rest Home</b>				d. STREET ADDRESS (If rural, give location) <b>2202 SPRUCE</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>VIOLA</b>		b. (Middle) <b>HENDERSON</b>		c. (Last) _____	
4. DATE OF DEATH		Month <b>11</b> - Day <b>27</b> - Year <b>54</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>W. STO</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>09 21 1884</b>		9. AGE (In years last birthday) <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>HANNIBAL MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Robert Laphley</b>		13b. MOTHER'S MAIDEN NAME <b>SUSAN STEVENS</b>		14. NAME OF HUSBAND OR WIFE <b>P.A. HENDERSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>NO</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>AGUSTA HENDERSON</b> ADDRESS <b>QUINCY ILL.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		Cerebral Hemorrhage				1 day	
ANTECEDENT CAUSES		DUE TO (b) _____					
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		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) _____		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 <b>Nov 26</b> , 19 <b>54</b> , to <b>Nov 27</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>Nov 26</b> , 19 <b>54</b> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Robert Lanning, M.D.</b>				23b. ADDRESS <b>Hannibal Mo</b>		23c. DATE SIGNED <b>11/29/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>11-30-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>ROBINSON CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>HANNIBAL MO.</b>	
DATE REC'D BY LOCAL REG. <b>11-30-54</b>		REGISTRAR'S SIGNATURE <b>Dr. E.M. Lusk</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W.R. Seale</b> ADDRESS <b>Hannibal Mo.</b>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED DEC 7 1954  
MARION CO. HEALTH DEPT.,  
DATE FILED DEC 7 1954

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

*W. R. Seshen*

Licensed Embalmer No. 9420

P. O. Address Summit 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.