

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2248

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 4461 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bismarck		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bismarck 0940	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) a. (First) Norman	b. (Middle) Lee	c. (Last) Henderson	4. DATE OF DEATH (Month) (Day) (Year) Jan. 11, 1955
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 7, 1910	9. AGE (In years last birthday) 44	# UNDER 1 YEAR (Months) 6	# UNDER 1 DAY (Days) 4	# UNDER 1 MIN. (Mins.)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor	10b. KIND OF BUSINESS OR INDUSTRY Mo-Pac Railroad	11. BIRTHPLACE (City and State or Foreign Country) Bismarck, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME George W. Henderson	13b. MOTHER'S MAIDEN NAME Katie McCoy	14. NAME OF HUSBAND OR WIFE Wanda Henderson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no	16. SOCIAL SECURITY NO. 702-16-4928	17. INFORMANT'S SIGNATURE OR NAME Mrs. Wanda Henderson, Bismarck, Mo.	ADDRESS
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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, asthma, 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) Concussion of Brain.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fall, hit post on head DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		E9049 45	

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 SUICIDE HOMICIDE (Specify) Traffic	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) 1 11 1955 m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Slip and fall on floor.
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22. I hereby certify that I attended the deceased from **1-11-1955**, to **7-11-1955**, that I last saw the deceased alive on **1-11-1955**, and that death occurred at **11:45** a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James H. Hoffmann	23b. ADDRESS Bismarck Mo	23c. DATE SIGNED 1-13-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 1/13/55	24c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery	24d. LOCATION (City, town, or county) (State) Bismarck, Mo.
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DATE REC'D BY LOCAL REG. Jan 13, 1955	REGISTRAR'S SIGNATURE Esther Rudloff	25. FUNERAL DIRECTOR'S SIGNATURE White Funeral Home	ADDRESS Ironton, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 18 1955

JAN 19 1955

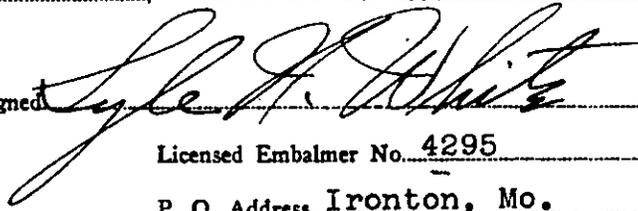
STATEMENT BY LICENSED EMBALMER

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 
Licensed Embalmer No. 4295
P. O. Address Ironton, 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.