

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 20 1955

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 265

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 Bonne Terre		c. LENGTH OF STAY (in this place) Life	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bonne Terre Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bonne Terre	
		d. STREET ADDRESS (If rural, give location) 419 North Division St.	

3. NAME OF DECEASED (Type or Print)	a. (First) Mary	b. (Middle) Emily	c. (Last) Henson	4. DATE OF DEATH (Month) (Day) (Year) Sept. 12, 1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 9/12/1865	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR 0 Days	IF UNDER 24 HRS. 0 Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and State or Foreign Country) Bonne Terre, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William Pratte	13b. MOTHER'S MAIDEN NAME Nancy Butler	14. NAME OF HUSBAND OR WIFE William Henson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME Albert Henson	ADDRESS Bonne Terre,
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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		Mo. INTERVAL BETWEEN ONSET AND DEATH 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) 332X.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Spine Regenerative Arthritis			

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)	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?

22. I hereby certify that I attended the deceased from 9-11, 1955, to 9-12, 1955, that I last saw the deceased alive on 9-11, 1955, and that death occurred at 4:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Jack W. Miller M.D.	23b. ADDRESS Bonne Terre Mo	23c. DATE SIGNED 9-14-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/14/55	24c. NAME OF CEMETERY OR CREMATORY Primrose Cemetery	24d. LOCATION (City, town, or county) (State) St. Francois County, MO.
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DATE REC'D BY LOCAL REG. Sept. 14, 1955	REGISTRAR'S SIGNATURE Ethel Rudloff	25. FUNERAL DIRECTOR'S SIGNATURE Everett Sparks	ADDRESS Bonne Terre Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

9561 21 70P

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 Everett Sparks

Licensed Embalmer No. 4287

P. O. Address Bone Lane

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.