

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38349**

FILED DEC 2 1955

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **9944**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>St. Louis Mo</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>48</b>
c. LENGTH OF STAY (In this place)		e. STREET ADDRESS (If rural, give location) <b>19 424 Maryland Ave.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>THOMAS</b>	b. (Middle) <b>N.</b>
		c. (Last) <b>HENDERSON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>NOVEMBER 14, 1955</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>April 6 1879</b>
9. AGE (In years last birthday) <b>76</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>8</b>	11. IF UNDER 24 HRS. Hours <b>8</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Bullinger Co Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Robert Sydney Hodges</b>	
13b. MOTHER'S MAIDEN NAME <b>Julia Crafton</b>		14. NAME OF HUSBAND OR WIFE <b>Mary Frances Henderson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>498-054341</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Fran Henderson</b>		ADDRESS <b>424 Maryland</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Prostate</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <b>with widespread metastasis</b>	
Morbid 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 <b>177 x</b>	
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) (Min.)		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>11-6-</b> 19 <b>55</b> , to <b>November 14, 1955</b> , that I last saw the deceased alive on <b>11-14</b> , 19 <b>55</b> and that death occurred at <b>8:30 am.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Edgar B. Coker MD</b>		23b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	
23c. DATE SIGNED <b>11-14-55.</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>Nov. 16, 1955</b>	
24c. NAME OF CEMETERY OR CREMATORY <b> Laurel Hill Gardens</b>		24d. LOCATION (City, town, or county) (State) <b> Pennsylvania St. Charles, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>NOV 15 1955</b>		REGISTRAR'S SIGNATURE <b>Charles Smith MD</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Bull-Campbell Mortuary</b>		ADDRESS <b>516 S. Delmar</b>	

(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.....  
*Pearl Morris*

Licensed Embalmer No.....*33*

P. O. Address.....*603 Beene*

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.