

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12332**

FILED APR 17 1956

|                                                                                                                                                                                                                                                 |  |                                                                                                        |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                             |                                                                                                                                   |                                            |                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------|--|
| BIRTH NO. _____                                                                                                                                                                                                                                 |  | REG. DIST. NO. <u>32</u>                                                                               |                                                            | PRIMARY REG. DIST. NO. <u>5109</u>                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                             | Registrar's No. <u>31</u>                                                                                                         |                                            |                                  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>BOLLINGER</u>                                                                                                                                                                                                 |  |                                                                                                        |                                                            | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>---a. STATE <u>MO.</u> b. COUNTY <u>BOLLINGER</u>                                                                                                                                                                                                                                                                                                   |                                                                             |                                                                                                                                   |                                            |                                  |  |
| b. CITY OR TOWN <u>RURAL CROOKED CREEK</u>                                                                                                                                                                                                      |  | c. LENGTH OF STAY (in this place) <u>lifetime</u>                                                      |                                                            | c. CITY OR TOWN <u>RURAL</u>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                             | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                                            |                                  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION _____                                                                                                                                                                                                   |  |                                                                                                        |                                                            | e. STREET ADDRESS (If rural, give location) <u>near MARGUAND 0090</u>                                                                                                                                                                                                                                                                                                                                                                         |                                                                             |                                                                                                                                   |                                            |                                  |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>ARTHUR</u> b. (Middle) <u>V</u> c. (Last) <u>HENDERSON</u>                                                                                                                                 |  |                                                                                                        | 4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 5, 1956</u> |                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                             |                                                                                                                                   |                                            |                                  |  |
| 5. SEX <u>M.</u>                                                                                                                                                                                                                                |  | 6. COLOR OR RACE <u>W.</u>                                                                             |                                                            | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>                                                                                                                                                                                                                                                                                                                                                                         |                                                                             | 8. DATE OF BIRTH <u>OCT. 15, 1879</u>                                                                                             |                                            |                                  |  |
| 9. AGE (In years last birthday) <u>76</u>                                                                                                                                                                                                       |  | IF UNDER 1 YEAR Months <u>5</u> Days <u>20</u>                                                         |                                                            | IF UNDER 24 HRS. Hours _____ Mins. _____                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                             |                                                                                                                                   |                                            |                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>                                                                                                                                       |  |                                                                                                        | 10b. KIND OF BUSINESS OR INDUSTRY _____                    |                                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. BIRTHPLACE (City and State or Foreign Country) <u>Bollinger Co. Mo.</u> |                                                                                                                                   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |                                  |  |
| 13a. FATHER'S NAME <u>JOHN M. HENDERSON</u>                                                                                                                                                                                                     |  |                                                                                                        | 13b. MOTHER'S MAIDEN NAME <u>SARAH SLINKARD</u>            |                                                                                                                                                                                                                                                                                                                                                                                                                                               | 14. NAME OF HUSBAND OR WIFE <u>MARY HENDERSON</u>                           |                                                                                                                                   |                                            |                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>                                                                                                                                                                    |  | 16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>                                            |                                                            | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Iley James, Marguand Mo.</u> ADDRESS _____                                                                                                                                                                                                                                                                                                                                                          |                                                                             |                                                                                                                                   |                                            |                                  |  |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.                   |  |                                                                                                        |                                                            | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Decompensation</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Cardiovascular disease</u><br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |                                                                             |                                                                                                                                   |                                            | INTERVAL BETWEEN ONSET AND 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 <u>2/1, 1953</u> to <u>4/5, 1956</u> , that I last saw the deceased alive on <u>4/4, 1956</u> , and that death occurred at <u>6 P.</u> m., from the causes and on the date stated above. |  |                                                                                                        |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                             |                                                                                                                                   |                                            |                                  |  |
| 23a. SIGNATURE (Degree or title) <u>John J. Myers MD</u>                                                                                                                                                                                        |  |                                                                                                        |                                                            | 23b. ADDRESS <u>Lutesville Mo</u>                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                             | 23c. DATE SIGNED <u>4/19/56</u>                                                                                                   |                                            |                                  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                         |  | 24b. DATE <u>April 7, 1956</u>                                                                         |                                                            | 24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                             | 24d. LOCATION (City, town, or county) (State) <u>Bollinger Co. Mo.</u>                                                            |                                            |                                  |  |
| DATE REC'D BY LOCAL REG. <u>4-12-56</u>                                                                                                                                                                                                         |  | REGISTRAR'S SIGNATURE <u>Mrs. Buford Chad Baker</u>                                                    |                                                            | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Baker Funeral Home, Lutesville, Mo.</u> ADDRESS _____                                                                                                                                                                                                                                                                                                                                                     |                                                                             |                                                                                                                                   |                                            |                                  |  |

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

(Licensed Embalmer's Statement on Reverse Side)

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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..... *J. E. Graham* .....

Licensed Embalmer No. *40*.....

P. O. Address *Lutesville*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.