

FILED DEC 7 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38049**
5036
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. LENGTH OF STAY (in this place) 3 mos.	c. CITY OR TOWN KANSAS CITY
d. FULL NAME OF HOSPITAL OR INSTITUTION 1312 East 23rd St.		STREET ADDRESS (If rural, give location) 1312 East 23rd St.	
3. NAME OF DECEASED (Type or Print) a. (First) FRUSANNA		b. (Middle)	c. (Last) HENDERSON
4. DATE OF DEATH NOV. 14, 1956		5. SEX Female 3 6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH Dec. 25, 1884	
9. AGE (In years last birthday) 71 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (City and State or Foreign Country) ROUND LAKE, MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME WILLIAM GRAINES		13b. MOTHER'S MAIDEN NAME LETTIE JACKSON	
14. NAME OF HUSBAND OSCAR HENDERSON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME MRS. PRESTON ALLEN ADDRESS 2207 Troost	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Hypertensive Heart		1 yr?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Inflammation		DUE TO (c) Auricular Fibrillation		4 day

19a. DATE OF OPERATION NO		19b. MAJOR FINDINGS OF OPERATION NO		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) no		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? no	

22. I hereby certify that I attended the deceased from **10-1-**, 19**56** to **11-14-**, 19**56**, that I last saw the deceased alive on **11-14-**, 19**56**, and that death occurred at **4p** m., from the causes and on the date stated above.

23a. SIGNATURE J. S. Wells M.D. (Degree or title)		23b. ADDRESS 2122 - E - 15th St.		23c. DATE SIGNED 11-20-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/20/56		24c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn	
24d. LOCATION (City, town, or county) KANSAS CITY		24e. (State) MISSOURI			

DATE REC'D BY LOCAL REG. 11-21-56		REGISTRAR'S SIGNATURE Neva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE Fannie T. Meek ADDRESS K.C., Mo.	
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(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 *Fannie D. Meek*

Licensed Embalmer No. *3818*

P. O. Address *Tomball, C.*

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.