

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1400

FILED APR 15 1957

STATE FILE NUMBER  
2804

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Illinois</i> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Roodhouse 8120 8</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Missouri Pacific Hosp.</i>		Length of stay in lb	32. STREET ADDRESS (If outside, give location) <i>108 West Clay St.</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>PROVIDE</i> Last <i>HENDERSON</i>			4. DATE OF DEATH Month <i>3</i> Day <i>21</i> Year <i>57</i>				
5. SEX <i>M O</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>FEB. 4, 1893</i>	9. AGE (In years last birthday) <i>64</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gulf Mobils + Ohio</i>		11. BIRTHPLACE (City and state or country) <i>Edgar Nebraska 1</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John P. Henderson Sr.</i>			14. MOTHER'S MAIDEN NAME <i>Dora Allen</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>709-10-9019</i>		17. INFORMANT <i>Ilah Henderson (wife) Roodhouse, Ill.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage from Gastro-intestinal tract.</i> <i>Hemorrhage from Esophageal Varices</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Esophageal Varices</i> DUE TO (c) <i>Hemochromatosis with cirrhosis &amp; Diabetes</i> <i>Hemochromatosis with cirrhosis &amp; Diabetes</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)					INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i> <i>several weeks</i> <i>several months</i>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1</i>					
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <i>2-5-57</i> to <i>2-21-57</i> and last saw <sup>him</sup> alive on <i>3-21-57</i> Death occurred at <i>4:05</i> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Benjamin H. Charles, Jr. M.D.</i>			22b. ADDRESS <i>West. Hosp. - St. Louis</i>		22c. DATE SIGNED <i>3-21-57</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		23b. DATE <i>3-21-57</i>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <i>Roodhouse, Ill.</i>		
24. FUNERAL DIRECTOR <i>Wolfe, Roodhouse, Ill.</i>		25. DATE RECD. BY LOCAL REG. <i>MAR 22 '57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i> <i>S.P.</i>			

Health, Welfare, Public Service  
300 1-56  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
1933-1940 WORKS-1947

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

**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 *Homer W. Fritz*.....

Licensed Embalmer No. .... 38

P. O. Address *St. Louis*.....

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.