

Health,
Welfare
Public
Service

300
1-56

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUL 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26188
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6281**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4205 W. Cook Home		d. STREET ADDRESS 4205 W. Cook	
3. NAME OF DECEASED (Type or print) Ellen Henderson		4. DATE OF DEATH Month 7 Day 3 Year 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIAGE STATUS <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 11-2-1890
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) Memphis, Tenn.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Home	
10c. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Chapel		14. MOTHER'S MAIDEN NAME Laura Hill.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 497-18-8032	
17. INFORMANT Corinne Walls		Address 4205 W. Cook	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hypertensive heart disease CONDITIONS, if any, which gave rise to above cause (b). STATE THE UNDERLYING CAUSE (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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.)	
20c. TIME OF INJURY Hour 5:00 Month, Day, Year		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 St. Louis Co. Mo	
21. I attended the deceased from 7-2-57 to 7-5-57 and last saw her alive on 6:30 PM. Death occurred at 5:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Oral S. McClure M.D.		22b. ADDRESS 4200a Easton Ave	
22c. DATE SIGNED 7-5-57		22d. CITY, TOWN, OR COUNTY (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 7-8-57	
23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo	
24. FUNERAL DIRECTOR Russell Undertaking Co. 2732 Pine		25. DATE RECD. BY LOCAL REG. JUL 6 '57	
26. REGISTRAR'S SIGNATURE Carl Smith M.D.		26. REGISTRAR'S SIGNATURE	

(Licensed Embalmer's Statement on Reverse Side)

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 *James A. Carter*.....

Licensed Embalmer No. *10410*

P. O. Address *152*

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