

Dept. Health,
 U. S. & Welfare
 Health Service
 V. S. 300
 Rev. 1-57

STANDARD CERTIFICATE OF DEATH

47810
 STATE FILE NUMBER

FILED JUL 15 1958 Registration District No. 347 Primary Registration District No. 4508 Registrar's No. 50

1. PLACE OF DEATH a. COUNTY <u>Stone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stone</u>	
b. CITY OR TOWN <u>Galena</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Galena 1040</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Galena Mo. Home</u>		d. STREET ADDRESS (If outside, give location) <u>Star Route 1</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Kerr Henson</u>			4. DATE OF DEATH Month Day Year <u>JUNE 10 - 1957</u>		
--	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 27, 1879</u>	9. AGE (Years of birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	---------------------------------------	--------------------------------------	---	--------------------------------

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 <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Stone County</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	--	--

13a. FATHER'S NAME <u>Francis Henson</u>	13b. MOTHER'S MAIDEN NAME <u>Alice Baker</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Mrs. Earnest Asher Galena</u> Address
--	----------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Army Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>870</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>	
	DUE TO (c) <u>4201</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 a.m. p.m. 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 COUNTY STATE
---	--	--	---

21. I attended the deceased from <u>1946</u> to <u>10 June 1957</u> and last saw her alive on <u>8 June 1957</u> Death occurred at <u>6:05 p.m.</u> m on the date stated above; and to the best of my knowledge from the causes stated.
--

22a. SIGNATURE <u>Opelijay M. W.</u> (Print name or title)	22b. ADDRESS <u>Galena Mo</u>	22c. DATE SIGNED <u>July 15 1958</u>
--	-------------------------------	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 12, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Henson Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Cape Fair, Missouri</u>
---	--------------------------------	---	--

24. FUNERAL DIRECTOR <u>Marsh Funeral Home, Aurora Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>July 11 - 58</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. J. L. Brown</u>
--	--	---

(Licensed Embalmer's Stamp on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

317

896L 9 T 500

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 Myself, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Robert L. Ward

Licensed Embalmer No. 3812
P. O. Address MD

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.