

Health, Welfare and Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008271

STATE FILE NUMBER

FILED FEB 28 1958

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 409

300
-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wellston</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Wellston</u> <u>4311</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>1108 Delaware Ave</u>		Length of stay in lb <u>30 years</u>	d. STREET ADDRESS (If outside, give location) <u>1108 Delaware Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES HENDERSHOT</u>			4. DATE OF DEATH Month Day Year <u>February 8, 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1868</u>	9. AGE (In years at birthday) <u>89</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building Construction</u>	11. BIRTHPLACE (City and state or country) <u>Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John Hendershot</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Reese</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Hendershot</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs Martha Cole, 1108 Delaware Avenue</u>			
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>Pulmonary congestion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio Sclerosis of heart disease</u>	DUE TO (c) <u>Malnutrition</u>	<u>420.0</u>	20 years <u>5 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Central arterio sclerosis with dementia.</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 <u>11-28-57</u> to <u>2-7-58</u> and last saw him alive on <u>2-7-58</u> Death occurred at <u>3:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>John Lawrence</u>			22b. ADDRESS <u>910 3720 Washington Ave St. L</u>		22c. DATE SIGNED <u>2-10-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 11, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>		
24. FUNERAL DIRECTOR <u>Shepard Funeral Home, 1167 Hamilton Ave</u>		25. DATE RECD. BY LOCAL REG. <u>2-10/58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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

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 *John S. Demmer*
Licensed Embalmer No. *4194*
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.