

FILED MAR 18 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH58-009263  
STATE FILE NUMBER

Registration District No. 75

Primary Registration District No. 5381

Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clinton</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>U.S. Highway 69 3 miles south</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Cameron</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Shoal Township</b>		Length of stay in 1b <b>****</b>	d. STREET ADDRESS (If outside, give location) <b>8 Miles south west</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Lynn</b> Middle <b>Allen</b> Last <b>Henderson</b>			4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1958</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-20-1894</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Clinton county Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Wm. A. Henderson</b>		13b. MOTHER'S MAIDEN NAME <b>Minnie Estep</b>		14. NAME OF HUSBAND OR WIFE <b>Deceased</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>493-42-4863</b>	17. INFORMANT Address <b>Wm. Henderson Independence Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive Internal Injuries</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 minutes</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					
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 checked="" 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.) <b>Auto Accident--Hit bridge</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. <b>11-00-3-5-58</b> p.m. <b>4:30</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>U.S. Highway 69 3 miles south</b>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. CITY, TOWN, OR LOCATION <b>CAMERON</b>		COUNTY <b>CLINTON</b>	STATE <b>MO</b>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>G. F. Warren, D. O. Coroner</b>			22b. ADDRESS <b>Lathrop, Mo.</b>		22c. DATE SIGNED <b>3-8-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 7 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Graceland Cemtery</b>		23d. LOCATION (City, town, or county) (State) <b>Cameron Missouri</b>
24. FUNERAL DIRECTOR <b>Poland Funeral Home</b>		ADDRESS <b>Cameron Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-9-58</b>		26. REGISTRAR'S SIGNATURE <b>Francis D Crawford</b>

(Licensed Embellisher's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Lawrence J. Mansfield* .....

Licensed Embalmer No. *4735* .....

P. O. Address *Cameron, N.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.