

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028488
STATE FILE NUMBER

FILED SEP 8 1958 Registration District No. 55 Primary Registration District No. 5209 Registrar's No. 69

S. 300
1-57
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1. PLACE OF DEATH a. COUNTY <u>Carroll</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>JACKSON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bogard</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</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>Leslie Hosp</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>2711 HARRISON</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>B.</u> Last <u>HENRY</u>			4. DATE OF DEATH Month <u>SEPT</u> Day <u>1</u> Year <u>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>Jan 16 - 1897</u>		9. AGE (In years last birthday) Months <u>61</u> Days <u>7</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dry Cleaning Laundry</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>cleaning clothes</u>		11. BIRTHPLACE (City and state or country) <u>CARROLL County, MO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>		13a. FATHER'S NAME <u>Frank Henry</u>		13b. MOTHER'S MAIDEN NAME <u>EMMA Reynolds</u>	
14. NAME OF HUSBAND OR WIFE <u>Lena H. Henry</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>499-09-1122</u>	
17. INFORMANT <u>Mrs. Walter Henry</u>		Address <u>2711 Harrison</u>		<u>K.C. Mo</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>APOPLEXY</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____					<u>334X</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 <u>9:00</u> a.m. Month <u>9-1-58</u> Day <u>1</u> Year <u>58</u>		20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>AT HOME of son</u>		20f. CITY, TOWN, OR LOCATION <u>BOGARD</u>		COUNTY <u>CARROLL</u> STATE <u>MO.</u>	
21. I attended the deceased from _____, to _____, and last saw her/him alive on _____ Death occurred at _____ m' on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>James O. Calvert Coroner</u>			22b. ADDRESS <u>113 E 4th CARROLLTON MO</u>		22c. DATE SIGNED <u>9-1-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Sept 4-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>COLOMA</u>		23d. LOCATION (City, town, or county) (State) <u>Bogard MO.</u>
24. FUNERAL DIRECTOR <u>DICKINSON FUNERAL HOME</u>		ADDRESS <u>Bogard Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-2-54</u>	26. REGISTRAR'S SIGNATURE <u>James Herbert Calvert</u>

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

SEP 12 1958

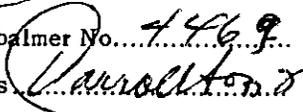
STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 4469

P. O. Address 

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.