Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-041681
STATE FILE NUMBER

FILED NOV 18 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9735

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 08 DEACONESS-Hosp. — Length of stay in lb 1 MONTH

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo — b. COUNTY ST. LOUIS
c. CITY OR TOWN MAPLEWOOD 4524 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 27 2501 BIG BEND (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First GRACE Middle - Last HENDERSON
4. DATE OF DEATH Month 10 Day 9 Year 58

5. SEX F
6. COLOR OR RACE WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH MAY-21-1904
9. AGE (In years last birthday) 54 — 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) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY AT-HOME
11. BIRTHPLACE (City and state or country) Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME ELMER J. WIDEMAN
13b. MOTHER'S MAIDEN NAME — WOODCOCK
14. NAME OF HUSBAND OR WIFE LEWIS. W. HENDERSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 498-22-4317
17. INFORMANT LEWIS. W. HENDERSON — Address ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1. Carcinoma of the Rt. breast with multiple Metastasis - (Skull, Chest & abdomen -
INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
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) 170 X
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 Jan 25 1957, to Oct. 9, 1958 and last saw her alive on Oct. 8, 1958
Death occurred at 4:55 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C.E. Williamson MD
22b. ADDRESS 6336 Clayton Road
22c. DATE SIGNED 10/10/58

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 10-13-58
23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW-CHURCH CEM.
23d. LOCATION (City, town, or county) GRUBVILLE (State) Mo

24. FUNERAL DIRECTOR JAY B. SMITH — ADDRESS MAPLEWOOD Mo
25. DATE RECD. BY LOCAL REG. OCT 11 '58
26. REGISTRAR'S SIGNATURE Carl Smith MD MDB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. .....

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.