

FILED JAN 6 1958

THE DIVISION OF HEALTH OF MISSOURI

58-045786

By affidavit  
# 11 # 17 Fun. Dir. 12/9/58  
# 14 Registration District No.

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

318

Primary Registration District No. 1003

Registrar's No. 11698

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri.</b> b. COUNTY <b>St. Louis.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Pine Lawn.</b> 4001 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
10. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Faith Hospital</b>		Length of stay in lb <b>10 Days</b>	d. STREET ADDRESS (If outside, give location) <b>6220 Westershoff</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Dewey</b> Middle <b>Wesley</b> Last <b>Henderson</b>			4. DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1898</b>		9. AGE (In years last birthday) <b>60</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milk Salesman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>	11. BIRTHPLACE (City and state or country) <b>Perry County, Tenn. Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	---	--	---

13a. FATHER'S NAME <b>Samuel Henderson</b>	13b. MOTHER'S MAIDEN NAME <b>Mathilda Dame</b>	14. NAME OF HUSBAND OR WIFE <b>Emilie Annela Henderson</b>
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>494-09-3752</b>	17. INFORMANT <b>Emilie Annela Henderson, 6220 Westershoff.</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>Tracheobronchial obstruction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>metastatic carcinoma of esophagus</b>	<b>6 mo</b>
	DUE TO (c) <b>150X</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>metastasis to subcutaneous tissue, liver, mediastinum</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		

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 **8/2/58** to **12/3/58** and last saw her alive on **12/3/58**  
Death occurred at **10:30 A** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Martin Bergmann MD</b>	22b. ADDRESS <b>4500 Olive St.</b>	22c. DATE SIGNED <b>12/4/58</b>
---	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-5-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Home Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Perryville, Mo.</b>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <b>Albert H. Hoppe 4700 Washington, Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 4 '58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>
---	--	---

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 *John J. Hines* .....  
Licensed Embalmer No. *4108* .....  
P. O. Address *St Louis Mo* .....

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.