

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045787
STATE FILE NUMBER

FILED JAN 5 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar 12232

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillips Hosp. yrs. 27		Length of stay in 1b. ST. STREET ADDRESS 1206 N. Ninth St. (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last HELEN HENDERSON			4. DATE OF DEATH Month Day Year Dec. 16, 1958		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 8, 1912	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) solicitor		10b. KIND OF BUSINESS OR INDUSTRY business services		11. BIRTHPLACE (City and state or country) Orleans, Minnesota	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Jacob Wallenberg		
14. MOTHER'S MAIDEN NAME Sofocinski			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. not known			17. INFORMANT Address J.E. Miller, 647 Amelia, Webster Gr.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Skull</i> <i>Brain Injury</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Fracture of Skull</i> DUE TO (c) <i>Brain Injury</i>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <i>Suffered when struck by</i> <i>falling machinery by one of</i> <i>Sarah and Budell about 4:15 p.m.</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>falling machinery by one of Sarah and Budell about 4:15 p.m.</i>	
20c. TIME OF INJURY Hour Month, Day, Year <i>4:15 p.m. 12 15 58</i>	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office, etc.) <i>19 Street</i>	20e. CITY, TOWN OR LOCATION COUNTY STATE <i>St Louis Mo</i>
21. I attended the deceased from <i>2:15 p.m.</i> to <i>2:15 p.m.</i> and last saw her/him alive on <i>12-18-58</i> . Death occurred at <i>12-18-58</i> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <i>Patrick J. Taylor Coroner</i>		22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>12-18-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE Dec. 19, 1958	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS M. J. Croghan 7146 Manchester Ave.	25. DATE RECD. BY LOCAL REG. DEC 18 '58	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> <i>mdb</i>
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ST. LOUIS, MO. (Licensed Embalmer's Statement on Reverse Side)

health, Welfare Public Service
300 1-56
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *V.E. Morris*.....

Licensed Embalmer No. *303*.....

P. O. Address *St Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.