

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007209

STATE FILE NUMBER

2 1237

Registration District No. _____ Primary Registration District No. _____ Registrar's Signature _____

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 No

c. CITY OR TOWN **Saint Louis** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **2402 Elliot** Length of stay in 1b _____

d. STREET ADDRESS (If outside, give location) **2404 Elliot** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Sidney Henderson

4. DATE OF DEATH Month Day Year
February 2, 1959

5. SEX **Male** 2 6. COLOR OR RACE **Negro** 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH **July 8, 1887** 9. AGE (In years last birthday) **71** 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) **Unemployed** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (City and state or country) **Tennessee** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Coin Henderson** 13b. MOTHER'S MAIDEN NAME **Unknown** 14. NAME OF HUSBAND OR WIFE **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. **Unknown** 17. INFORMANT Address **Dora Henderson 2404 Elliot**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Arteriosclerotic Heart Disease**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) **Arteriosclerosis**
DUE TO (c) **420.0**

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 NO 2.

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 Month, Day, Year a.m. p.m. _____

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 _____ to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **[Signature]** 22b. ADDRESS **1300 Clark** 22c. DATE SIGNED **2/4/59**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **2/7/59** 23c. NAME OF CEMETERY OR CREMATORY **Oakdale Cemetery** 23d. LOCATION (City, town, or county) (State) **Berkley, Missouri**

24. FUNERAL DIRECTOR ADDRESS **E. B. Koonce 1221 N. Grand** 25. DATE RECD. BY LOCAL REG. **FEB 4 '59** 26. REGISTRAR'S SIGNATURE **Loan Smith, M.D.**

(Licensed Embalmer's Statement on Reverse Side)

300
-57
0
91
0

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part 1 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 *Darrence Brown*

Licensed Embalmer No. 4155

P. O. Address 1221 N. Grand

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.