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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007211

STATE FILE NUMBER

FILED MAR 10 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2049

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St Louis — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Frisco Employees — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Green
c. CITY OR TOWN: Springfield 0396 — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2506 N. Johnson — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Vester Middle: Last: Henry

4. DATE OF DEATH: Month: Feb Day: 26 Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 23, 1901
9. AGE (In years last birthday): 57 yr — 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): Lineman
10b. KIND OF BUSINESS OR INDUSTRY: Rail Road
11. BIRTHPLACE (City and state or country): Cedar Gap, Mo.
12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME: Lawson Henry
13b. MOTHER'S MAIDEN NAME: Margaret James
14. NAME OF ~~HUSBAND OR~~ WIFE: Opal Fern Hays Henry

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.: 702-03-5095
17. INFORMANT: Wife — Address: Same - 2506 N. Johnson

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): Lymphosarcoma of mouth and nose with metastases — INTERVAL BETWEEN ONSET AND DEATH: 4 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 200.1
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~~ ☐

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 1-3-59, to 2-26-59 and last saw him alive on 2-25-59
Death occurred at 5:59 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Norman Williams M.D.
22b. ADDRESS: 4960 Laclede Ave
22c. DATE SIGNED: 2-26-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-28-59
23c. NAME OF CEMETERY OR CREMATORY: Local Cemetery
23d. LOCATION (City, town, or county) (State): Springfield, Mo.

24. FUNERAL DIRECTOR: Albert H. Hoppe — ADDRESS: 4700 Washington
25. DATE RECD. BY LOCAL REG.: FEB 26 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(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 J W M Binkley

Licensed Embalmer No. 3653

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.