

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014544

STATE FILE NUMBER

Registration District No. 306 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**FILED MAY 12 1959**

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before, a. STATE <u>MO</u> b. COUNTY <u>ST. CHARLES</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>DARDENE TOWN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. PETERS</u> <u>0920</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u>		Length of stay in 1b <u>—</u>	d. STREET ADDRESS (If outside, give location) <u>RURAL</u>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>RUSSEL</u> Middle <u>B</u> Last <u>HENRY</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>1</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <del>DIVORCED</del> <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 15 - 1871</u>	9. AGE (In years last birthday) <u>87</u>	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) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>ST. CHARLES Co. MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>JOHN L. HENRY</u>		13b. MOTHER'S MAIDEN NAME <u>OWEN'S</u>		14. NAME OF HUSBAND OR WIFE <u>HENRY MAGGIE DEED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>ROLLA HENRY</u> Address <u>ST. PETERS MO</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Deceased last visit to Doctor 5 years ago - The Dr. now dead - I know the family personally visited the premises, found the body dead in bed at home 11:30 PM. 5-1-1959</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>the premises</u> DUE TO (c) <u>Emergency evidence showed the deceased died a natural death.</u>		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 (a) <u>died a natural death.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Ed K. Keithy Registrar Dardene Twp</u>	22b. ADDRESS <u>St Charles Co. Mo.</u>	22c. DATE SIGNED <u>5-2-59</u>
23a. BURIAL, CREMATION, or other disposition (specify)	23b. DATE <u>5-4-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cem</u>
23d. LOCATION (City, town, or county) <u>Dallan Mo</u>		(State)

24. FUNERAL DIRECTOR <u>Keithy Funeral Home Dallan Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>5-3-1959</u>	26. REGISTRAR'S SIGNATURE <u>Ed K. Keithy</u>
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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 .....  
*E. Keilty*

Licensed Embalmer No. .... *877*

P. O. Address ..... *D. Fallon*

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.