

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018416

Health,  
Welfare  
Public  
Service

Registration District No. 206 Primary Registration District No. 3047 STATE FILE NUMBER Registrar's No. 27

FILED MAY 25 1959

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-57

1. PLACE OF DEATH a. COUNTY <b>Madison</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Madison</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Fredericktown</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Fredericktown</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>809 S. Maple</b>		Length of stay in lb <b>36 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>809 S. Maple</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Truman</b> Middle <b>Reuben</b> Last <b>Henline</b>			4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 15, 1876</b>
9. AGE (In years last birthday) <b>82</b>		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) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber shop</b>	11. BIRTHPLACE (City and state or country) <b>Colfax, Ill.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>Joseph Henline</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary M. Hughes</b>		14. NAME OF HUSBAND OR WIFE <b>Jennie Henline</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>491-36-4848</b>	17. INFORMANT <b>Mrs. Hazel Price</b> Address <b>2911a Wyoming St. Louis, Mo.</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>Coronary occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary sclerosis</b>			<b>6 months</b>
DUE TO (c) <b>generalized arterio-sclerotic</b>			<b>2 years</b>
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 <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.) <b>4201</b>
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>November 1948</b> to <b>May 8, 1959</b> and last saw him alive on <b>May 6, 1959</b> Death occurred at <b>7:00 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree optional) <b>Kenneth P. Wheeler, D.O.</b>		22b. ADDRESS <b>Fredericktown, Mo.</b>	22c. DATE SIGNED <b>5-11-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/10/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Christian Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Fredericktown, Mo.</b>
24. FUNERAL DIRECTOR <b>Najim Funeral Home,</b>		25. DATE RECD. BY LOCAL REG. <b>5-11-1959</b>	26. REGISTRAR'S SIGNATURE <b>Florence Hicks</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 25 1959

REGISTRATION  
FILE NO. 337-2

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 *Charles McEachy* .....

Licensed Embalmer No. *4852* .....

P. O. Address *Fredrickton* .....

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.