

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018485
STATE FILE NUMBER

FILED MAY 25 1959

Registration District No. 227 Primary Registration District No. 5-805 Registrar's No. 16

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>MONROE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON</u>		c. CITY <u>FLORIDA</u> OR TOWN <u>JEFFERSON TWP.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>14 MI. E. OF PARIS, MO.</u>		d. STREET (If outside, give location) ADDRESS <u>14 MI. E. OF PARIS, MO.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DUARD DOOLEY HENDERSON</u>		4. DATE OF DEATH Month Day Year <u>MAY 13, 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 11, 1901</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>GEN. MDSE.</u>	9c. AGE (In years last birthday) <u>58</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>2</u> IF UNDER 24 HRS.: Hours <u>-</u> Min. <u>-</u>
10a. FATHER'S NAME <u>JAMES E. HENDERSON</u>		10b. MOTHER'S MAIDEN NAME <u>ESTAVIA DOOLEY</u>	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>JAMES E. HENDERSON</u>		13b. MOTHER'S MAIDEN NAME <u>ESTAVIA DOOLEY</u>	
14. NAME OF HUSBAND OR WIFE <u>FRANCES K. HENDERSON</u>		Address <u>STOUTSVILLE MO.</u> <u>AFD #1</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>486-386982</u>	
17. INFORMANT <u>Mrs. Frances Henderson</u>		Address <u>STOUTSVILLE MO.</u> <u>AFD #1</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>Coronary embolism</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>2 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4201	
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. _____ Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <u>1-16-59</u> to <u>5-13-59</u> and last saw him alive on <u>5-13-59</u> Death occurred at <u>9:30</u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <u>F. M. Sumner, D.O.</u>	
22a. ADDRESS <u>Monroe City, Mo.</u>		22c. DATE SIGNED <u>5-18-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY 16, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE</u>	23d. LOCATION (City, town, or county) (State) <u>PARIS, MO.</u>
24. FUNERAL DIRECTOR <u>E. H. Agnew</u>	ADDRESS <u>Paris, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-16-59</u>	26. REGISTRAR'S SIGNATURE <u>F. A. Barnette, D.</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

550

VS MAR 29 1960

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. H. Agnew*

Licensed Embalmer No. *4000*

P. O. Address *Paris, 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.