

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-026738
STATE FILE NUMBER

FILED JUL 17 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. 6374

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>WAYNE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>PIEDMONT</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>R.R. # 2</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL HENSON</u>			4. DATE OF DEATH Month Day Year <u>7 - 6 - 59</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-59</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>1</u> Days <u>10</u> Hours <u>53</u> IF UNDER 24 HRS. Min. <u>53</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>DONALD WAYNE HENSON</u>		13b. MOTHER'S MAIDEN NAME <u>LINDA SUE WILLIAMS</u>		14. NAME OF HUSBAND OR WIFE <u>LINDA HENSON, R.R.#2, Piedmont, Mo.</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>LINDA HENSON, R.R.#2, Piedmont, 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>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>776x</u>	
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		

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
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21. I attended the deceased from 7-4-59 to 7-6-59 and last saw her/him alive on 7-6-59
Death occurred at 1:30 P.M. 7-6-59 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Marvin H. Liberman, M.D.</u>	22b. ADDRESS <u>17 St. Charles Rk Rd. St. Ann</u>	22c. DATE SIGNED <u>7/6/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7/7/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon</u>	23d. LOCATION (City, town, or county) (State) <u>St. Ann. Mo</u>
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24. FUNERAL DIRECTOR <u>COLLIER, MORTUARY</u>	ADDRESS <u>St. Ann, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>JUL 6 '59</u>	26. REGISTRAR'S SIGNATURE <u>Local Smith M.D.</u>
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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

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

No Embalming

Signed
Sheldon Collins

Licensed Embalmer No. *3382*
P. O. Address
S. T. Collins

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.