JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED OCT 13 1959

59-032384

STATE FILE NUMBER

NDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4717

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY
Length of stay in 1b: 27 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY Jackson
c. CITY OR TOWN KANSAS CITY
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 2035 BRIGHTON
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: MONROE Middle: Last: HENDERSON

4. DATE OF DEATH Month Day Year: September 28, 1959

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 5-2-88
9. AGE (last birthday): 71
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (City and state or country): Spartansburg, S. C.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Fait Henderson
13b. MOTHER'S MAIDEN NAME: Mildred Bowling
14. NAME OF HUSBAND OR WIFE: Magdalena HENDERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 492 14 1447
17. INFORMANT: VA Hospital Official Records, K.C. Mo Address

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) Bronchopneumonia, R&LLL
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Pancytopenia
DUE TO (c) Chloromycetin sensitivity (clinical)
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)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 June 7, 1959 to September 28, 1959 and last saw him alive on
Death occurred at 8:35 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. A. Turner (Degree or title) J. A. TURNER, M.D.
22b. ADDRESS VA Hospital Kansas City, Mo.
22c. DATE SIGNED 9-28-59

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: SEPT 30, 1959
23c. NAME OF CEMETERY OR CREMATORY: FLORAL HILLS CEM
23d. LOCATION (City, town, or county) (State): KANSAS CITY, MO.

24. FUNERAL DIRECTOR ADDRESS: D. W. NEWCOMER'S SONS K. C. MO.
25. DATE RECD. BY LOCAL REG.: 9-29-59
26. REGISTRAR'S SIGNATURE: Nova Minshall

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Albert L. Savage

Licensed Embalmer No. 4812

P. O. Address Kansas C

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.