

Dept. Health,
duc., & Welfare
U. S. Public
Health Service

FILED VS OCT 23 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-036209
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4928

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION QUEEN OF THE WORLD		Length of stay in lb 40 yrs.	d. STREET ADDRESS (If outside, give location) 2831 WABASH		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FRIEMAN HENSON			4. DATE OF DEATH Month Day Year OCTOBER 11, 1959		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-1892	9. AGE (In years, last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 67 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FULLMAN PORTER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Pine Bluff, Arkansas		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Rev. Dan Henson		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE SUSIE HENSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT Address SUSIE HENSON 2831 WABASH K.C. MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PEPTIC ULCERATION OF THE ESOPHAGUS WITH PERFORATION					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					5391
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to those reported in PART I (e) PLEURITIS; HYDROTHORAX; GANGRENE OF SCROTUM WITH PERFORATION OF PROSTATIC URETHRA					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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	
21. I attended the deceased from <u>9-30-59</u> to <u>10-11-59</u> and last saw her alive on <u>10-11-59</u> Death occurred at <u>9:25 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>George P. Mc Donald M.D.</i>			22b. ADDRESS <i>2604 Prospect</i>		22c. DATE SIGNED <i>10-13-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-16-59	23c. NAME OF CEMETERY OR CREMATORY Highland		23d. LOCATION (City, town, or county) (State) Kans. City, Missouri	
24. FUNERAL DIRECTOR ADDRESS Watkins Bros. Funeral Home 18th & Benton			25. DATE RECD. BY LOCAL REG. 10-13-59	26. REGISTRAR'S SIGNATURE <i>Lera Minshall</i>	

The registrar is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949.

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.

Bruce P. Mc Donald 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

Signed *Bruce P. Watkins*

Licensed Embalmer No. *4510*

P. O. Address *18th & Benton*

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.