

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 3 0 1959

59-041955

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **210590**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b 4/13/1951	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION MASONIC HOME HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5351 Delmar Boulevard Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) KATHRYN HENSHAW			4. DATE OF DEATH Month II Day 16 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1/1879	9. AGE (last birthday) 80 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME FRANK MACH		13b. MOTHER'S MAIDEN NAME ELIZABETH KOLAR		14. NAME OF HUSBAND OR WIFE WILLIAM HENSHAW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Masonic Home of Mo.-5351 Delmar Blvd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. IMMEDIATE CAUSE (a) CEREBRAL ACCIDENT IMMEDIATE CAUSE (a) CEREBRAL ACCIDENT Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO (c) 420.0				INTERVAL BETWEEN ONSET AND DEATH 16 hrs unknown	
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <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 1/1/1956 to 11/16/1959 and last saw ^{her} him alive on 11/15/1959 Death occurred at 2/45 AM on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Robert A. Hall, M.D. (Degree or title)			22b. ADDRESS 3902 Lafayette Ave.		22c. DATE SIGNED 11-16-59
23a. BURIAL, CREMATION, REQUIVAL (Specify) Requival	23b. DATE 11-18-59	23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City, town, or county) (State) Louisiana, Missouri	
24. FUNERAL DIRECTOR Ziegenheim Brothers-6409 Gravois Ave.		ADDRESS	25. DATE RECD. BY LOCAL REG. NOV 17 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D. <i>mjs</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Van M. Sigemore

Licensed Embalmer No. 4343

P. O. Address _____

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.