

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 3 2 4

FILED VS DEC 21 1959

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 617

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>2 weeks</u>	c. CITY OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Missouri Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>11 West Walnut</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard William Henderson</u>			4. DATE OF DEATH Month Day Year <u>Dec. 12 1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</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>8-4-'15</u>	9. AGE (last birthday) <u>44</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>insulator</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Mexico, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>John Henderson</u>		13b. MOTHER'S MAIDEN NAME <u>Elean Roberts</u>		14. NAME OF HUSBAND OR WIFE <u>Dorothy Henderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No, no, or unknown) (If yes, give war or dates of service) <u>yes W.W.II</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Hospital Record, Columbia, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>UREMIA</u>					
DUE TO (c) <u>CHRONIC LYMPHATIC LEUKEMIA</u>					
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 type="checkbox"/> No <input type="checkbox"/> Unknown
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 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 <u>12-4-59</u> to <u>12-12-59</u> and last saw her/him alive on <u>12-12-59</u> Death occurred at <u>3:31</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Michael J. Arjarian M.D.</u>			22b. ADDRESS <u>U. of Mo Med. Center</u>		22c. DATE SIGNED <u>12-12-59</u>
22d. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/15/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Columbia</u>	23d. LOCATION (City, town, or county) <u>Columbia, Mo.</u>		(State)
24. FUNERAL DIRECTOR <u>Mrs Stuart Parker, Columbia, Mo</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Dec 14 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 22 1959

FEB 9 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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed George R. T.

Licensed Embalmer No. 442

P. O. Address Columb

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.