

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 45 1 6 1

FILED VS DEC 28 1959

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3061 Registrar's No. 492

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ST. FRANCOIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FLAT RIVER</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. FRANCOIS</u> c. CITY OR TOWN <u>FLAT RIVER</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>4th St.</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>CARRIE O. HENDERSON</u> <b>4. DATE OF DEATH</b> Month Day Year <u>Dec 21, 1959</u>															
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>FEB 10, 1885</u>		<b>9. AGE (last birthday)</b> <u>84</u>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HR</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done if retired) <u>HOUSEWIFE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOUSE WIFE</u>				<b>11. BIRTHPLACE</b> (City and state or country) <u>MADISON CO.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>					
<b>13a. FATHER'S NAME</b> <u>HENDERSON THOMAS UNDER</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>NANCY UNDERWOOD</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>WILLIAM HENDERSON</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> Address <u>OTTO HENDERSON FLAT RIVER MO.</u>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Gangrene Rt. Leg</u> DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____											
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>										<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION,</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____	
<b>21. I attended the deceased from</b> <u>Dec 4 59</u> to <u>Dec 21 59</u> and last saw her <sup>her</sup> alive on <u>Dec 20 - 1959</u> Death occurred at <u>9 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.															
<b>22a. SIGNATURE</b> (Degree or title) <u>C. H. Applegate M.D.</u>						<b>22b. ADDRESS</b> <u>Rivermines, MO</u>			<b>22c. DATE SIGNED</b> <u>12-23-59</u>						
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>			<b>23b. DATE</b> <u>DEC 24, 1959</u>			<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>WOODLAWN CEM.</u>			<b>23d. LOCATION</b> (City, town, or county) (State) <u>NEAR ESTHER, MO.</u>						
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>R. CALDWELL &amp; SONS FLAT RIVER</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>Dec. 23, 1959</u>				<b>26. REGISTRAR'S SIGNATURE</b> <u>Esther Rudloff</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MO (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 me  
or by DONALD Dale Caldwell, Student Embalmer No. 587

working under my personal supervision.

Student Donald Dale Caldwell Signed R. Caldwell  
Signature of Student Embalmer

Licensed Embalmer No. 2531

P. O. Address Flat River

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.