

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033890

FILED VS SEP 19 1960

042

Primary Registration District No. 1000

Registrar's No. 9 64

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>42 years</i>	c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>1035 E. Lake Blvd.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>1035 E. Lake Blvd.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Owen</i> Middle <i>P.</i> Last <i>Henson</i>			4. DATE OF DEATH Month <i>September</i> Day <i>10</i> Year <i>1960</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>May 30, 1888</i>	9. AGE (last birthday) <i>78</i>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired grocer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retail Groceries</i>	11. BIRTHPLACE (City and state or country) <i>Platte County, Mo.</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13a. FATHER'S NAME <i>Hillyard Henson</i>		13b. MOTHER'S MAIDEN NAME <i>Susan Palston</i>		14. NAME OF HUSBAND OR WIFE <i>Zona Henson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>486-32-3939</i>	17. INFORMANT Address <i>(wife) Zona Henson 1035 E. Lake Blvd</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Apoplexy</i>					INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertension</i>					<i>6 weeks</i>
DUE TO (c) <i>Senility</i>					
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 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 <input type="checkbox"/> Month, Day, Year	Hour a.m. p.m.				
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 <i>April 15, 1960</i> to <i>Sept. 10, 1960</i> and last saw her him alive on <i>September 7, 1960</i> Death occurred at <i>7:15 P. M.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURES (Degree or title) <i>A. N. Henson M.D.</i>			22b. ADDRESS <i>1201 Jule St., St. Joseph, Mo.</i>		22c. DATE SIGNED <i>9-12-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Sept. 13, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>	23d. LOCATION (City, town, or county) <i>St. Joseph, Mo.</i>	(State)	
24. FUNERAL DIRECTOR <i>Clark Funeral Home</i>		ADDRESS <i>St. Joseph, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>September 12, 1960</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>	

DOCUMENT

H.N. Tospo 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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

E. A. Clark

Licensed Embalmer No. 4230

P. O. Address St. George

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.