MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-019076
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4934

FILED JUN 8 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4830 Ashland
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: FRED Middle: NMN Last: HENRY
4. DATE OF DEATH: Month: MAY Day: 22 Year: 1961
5. SEX: Male
6. COLOR OR RACE: Colored
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: April 30, 1918
9. AGE (last birthday): 43
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HR: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (City and state or country): Miss.
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Clon Neall Henry
13b. MOTHER'S MAIDEN NAME: Ella Crockdell
14. NAME OF HUSBAND OR WIFE: Clendell Henry
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Clendell Henry Address: 4830 Ashland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMATOSIS, PRIMARY SITE LEFT KIDNEY (RENAL CELL CARCINOMA)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 180X
INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): HYPERTENSIVE CARDIOVASCULAR DISEASE
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 SEPT. 6, 1948 to MAY 22, 1961 and last saw her/him alive on MAY 22, 1961
Death occurred at 10:55 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: C. Vermillion, M.D. (Degree or title): M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 5/23/61
23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: 5-29-61
23c. NAME OF CEMETERY OR CREMATORY: Father Dickson
23d. LOCATION (City, town, or county) (State): St. Louis, Co. Missouri
24. FUNERAL DIRECTOR: S. J. Watson ADDRESS: 2769 Chouteau Ave.
25. DATE RECD. BY LOCAL REG.: MAY 25 1961
26. REGISTRAR'S SIGNATURE: Joan Smith M.D.

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 James A Carter

Licensed Embalmer No. 4681

P. O. Address St. Louis Mo

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.