

MOUR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042494
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10490**

AMENDED

FILED NOV 28 1961

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Length of stay in 1b _____
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **St. Anthony's Hosp.** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Mo.** b. COUNTY _____
c. CITY OR TOWN **St. Louis** Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) **8617 Minnesota St.** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last **Phil T Henderson** 4. DATE OF DEATH Month Day Year **11 10 1961**

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **9/2/1878** 9. AGE (last birthday) **83** 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) **Retired** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) **Hoffman, Ill.** 12. CITIZEN OF WHAT COUNTRY **U.S.A**

13a. FATHER'S NAME **Unk.** 13b. MOTHER'S MAIDEN NAME **Unk.** 14. NAME OF HUSBAND OR WIFE **Mary Henderson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **Unk.** 17. INFORMANT **Elsie Krieger 8617 Minnesota Ave. St. Louis** Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Myocardial Infarction** INTERVAL BETWEEN ONSET AND DEATH **5 wks.**
DUE TO (b) **arterio-sclerotic heart**
DUE TO (c) **disease with myocardial damage 1 yr.**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) **Osteo-arthritis** 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.) **4200**

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 **Oct. 1-61** to **Nov 10-61** and last saw him alive on **Nov 10-61**
Death occurred at **2:20 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) **George A. O'Sullivan, M.D.** 22b. ADDRESS **7629 Ivory Ave.** 22c. DATE SIGNED **11-11-61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **11/13/61** 23c. NAME OF CEMETERY OR CREMATORY **Mt. Hope Cemetery** 23d. LOCATION (City, town, or county) (State) **St. Louis County, Mo.**

24. FUNERAL DIRECTOR ADDRESS **Edward Fendler 5611 So. Grand Blvd.** 25. DATE RECD. BY LOCAL REG. **NOV 12 1961** 26. REGISTRAR'S SIGNATURE **Loan Smith, M.D.**

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Geo J. Busde

Licensed Embalmer No. 3989

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.