

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-029466  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2170

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED JUL 31 1962</b>	
1. PLACE OF DEATH a. COUNTY <b>St. Louis</b> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch, Mo.</b> Length of stay in lb <b>11-1/3 yr</b> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rob't. Koch Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b> City (Institution) c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>42 34 Norfolk</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>(none)</b> Last <b>Henson</b>	
4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-4-85</b>
9. AGE (last birthday) <b>77 years</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Lead&amp;Zinc Mines</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	13a. FATHER'S NAME <b>William Henson</b>
13b. MOTHER'S MAIDEN NAME <b>Minerva Stanifer</b>	14. NAME OF HUSBAND OR WIFE <b>-----</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>	16. SOCIAL SECURITY NO. <b>None</b>
17. INFORMANT <b>Records Koch Hosp., Koch, Mo.</b>	Address <b>Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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 INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <b>3-23-51</b> to <b>7-24-62</b> and last saw him alive on <b>7-23-62</b> Death occurred at <b>10 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>H.A. Harris MD</b> (Deceased or title)	22b. ADDRESS <b>Robt. Koch Hosp., Koch, Mo.</b>
22c. DATE SIGNED <b>7-24-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal (Mtr)</b>	23b. DATE <b>July 28, 1962</b>
23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) (State) <b>Lonedell, Mo.</b>
24. FUNERAL DIRECTOR <b>Kriegshausner</b> ADDRESS <b>4228 S. Kingshighway Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>7-25-62</b>
26. REGISTRAR'S SIGNATURE <b>J. M. Murphy MD</b>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

VS 300 Rev. 4/59  
1 4000  
2 2189  
3  
4 0  
5 0  
6  
7 0  
8 2  
9 0021  
10  
11  
12 41-0  
13

**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 Edwin A. M. Aernatt

Licensed Embalmer No. 3024

P. O. Address \_\_\_\_\_

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.