

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-039250

STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 559v Registrar's No. 153

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 8 1962	
1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Joachim</u> Length of stay in lb <u>5</u> hours	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jefferson Memorial Hosp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jefferson</u>	
c. CITY OR TOWN <u>Festus</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <u>116 Harrison Lane</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary Cecelia</u> Middle <u>Henneman</u> Last <u>Henneman</u>	
4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1896</u>
9. AGE (last birthday) <u>66</u> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (City and state or country) <u>Uniontown, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Louis A. Ponder</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Kirn</u>	
14. NAME OF HUSBAND OR WIFE <u>Roman H. Henneman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Roman H. Henneman, Festus, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Gen Cerebrovascular sclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephrosclerosis. Cardiovasc. disease</u> 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 _____ a.m. _____ p.m. Month, Day, Year _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>Oct 30, 62</u> to <u>Oct 30, 62</u> and last saw her/him alive on <u>Oct 30, 62</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>William Bolger, MD</u>	
22b. ADDRESS <u>Festus, Mo</u>	
22c. DATE SIGNED <u>11/1/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>Nov. 3, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Catholic</u>	
23d. LOCATION (City, town, or county) (State) <u>Crystal City, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Vinyard Funeral Home, Festus, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>11-1-62</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 VS 300 Rev. 4/59
 1 0500
 2 0506
 3 2
 4 1
 5 1
 6
 7 0
 8 2
 9 331X
 10
 11
 12 1-0
 13 1-0
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 Donald H. Wingard

Licensed Embalmer No. 44608

P. O. Address Festus, 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.