

JUN 2 1970

DEPARTMENT OF PUBLIC HEALTH AND WELFARE - MISSOURI DIVISION OF HEALTH
(PHYSICIAN OR CORONER)

124 70 0021151
STATE FILE NUMBER

CERTIFICATE OF DEATH

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 252

DO NOT WRITE ON THIS STUB

9. 1

10a. 66

10b. 02

11. 0

12. 1

13. 4329

14. 4

15. 4

16.

17.

18. 2

19. CREDITS

20. 1-0

VS 300
Rev. 1/70

40940

5. 02

DECEASED

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

6. 0620

PARENTS

CAUSE

CERTIFIER

BURIAL

DECEASED—NAME FIRST MIDDLE LAST			SEX	DATE OF DEATH (MONTH, DAY, YEAR)		
1. <u>Beulah Lillian Henson</u>			<u>2. F.</u>	<u>3. May 19, 1970</u>		
RACE WHITE, NEGRO, AMERICAN INDIAN, ETC. (SPECIFY)	AGE—LAST BIRTHDAY (YEARS)	UNDER 1 YEAR MOS. DAYS	UNDER 1 DAY HOURS MIN.	DATE OF BIRTH (MONTH, DAY, YEAR)	COUNTY OF DEATH	
4. <u>White</u>	5a. <u>66</u>	5b.	5c.	<u>6. Sept. 7, 1903</u>	<u>7. St. Francois</u>	
CITY, TOWN, OR LOCATION OF DEATH			INSIDE CITY LIMITS (SPECIFY YES OR NO)	HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER)		
8. <u>St. Francois Twp. Farmington rural</u>			7c. <u>No</u>	<u>7d. Mineral Area Hospital</u>		
STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY)	CITIZEN OF WHAT COUNTRY	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY)	SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME)			
9. <u>Missouri</u>	10. <u>U.S.A.</u>	10. <u>Married</u>	<u>11. Percy Everett Henson</u>			
SOCIAL SECURITY NUMBER		USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED)		KIND OF BUSINESS OR INDUSTRY		
12. <u>488-20-4897</u>		13a. <u>Home maker</u>		13b.		
RESIDENCE—STATE	COUNTY	CITY, TOWN, OR LOCATION		INSIDE CITY LIMITS (SPECIFY YES OR NO)	STREET AND NUMBER	
14a. <u>Missouri</u>	14b. <u>Madison</u>	14c. <u>Fredericktown</u>		14d. <u>No</u>	<u>14e. Star Rt.</u>	
FATHER—NAME FIRST MIDDLE LAST			MOTHER—MAIDEN NAME FIRST MIDDLE LAST			
15. <u>Ellis Kemp</u>			16. <u>Elmora Anthony</u>			
INFORMANT—NAME			MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)			
17a. <u>Percy E. Henson</u>			17b. <u>Star Rt. Fredericktown, Missouri 63645</u>			
PART I. DEATH WAS CAUSED BY:			[ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)]			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. IMMEDIATE CAUSE						
(a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:						<u>3 or 4 days</u>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST			(b) <u>Quadriplegia</u> DUE TO, OR AS A CONSEQUENCE OF:			<u>1 month</u>
			(c) <u>Arteriosclerosis of the basilar cerebral arteries</u>			<u>1½ months</u>
PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)				AUTOPSY (YES OR NO)	IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH	
19. <u>No</u>				19a. <u>No</u>	19b. <u>No</u>	
ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY)	DATE OF INJURY (MONTH, DAY, YEAR)	HOUR	HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18)			
20a.	20b.	20c.	20d.			
INJURY AT WORK (SPECIFY YES OR NO)	PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY)	LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE)	IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS.			
21a.	21b.	21c.	21d. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			
CERTIFICATION—PHYSICIAN	MONTH DAY YEAR	MONTH DAY YEAR	AND LAST SAW HIM/HER ALIVE ON MONTH DAY YEAR	I DID/DID NOT VIEW THE BODY AFTER DEATH.	DEATH OCCURRED AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED.	
21e. <u>Mar. 20 70</u>	21f. <u>TO</u>	21g. <u>May 19 70</u>	21h. <u>May 19 70</u>	21i. <u>Did not</u>	21j. <u>8:45p.</u>	
CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED.						
22a.						
CERTIFIER—NAME (TYPE OR PRINT)			SIGNATURE	DEGREE OR TITLE	DATE SIGNED (MONTH, DAY, YEAR)	
23a. <u>Dr. W. A. Rohlfing, D.O.</u>			23b. <u>[Signature]</u>	23c. <u>M.D.</u>	23d. <u>May 22, 1970</u>	
MAILING ADDRESS—CERTIFIER			STREET OR R.F.D. NO.	CITY OR TOWN	STATE	ZIP
24a. <u>225-A W. Main,</u>			<u>Flat River,</u>	<u>Missouri</u>	<u>63601</u>	
BURIAL, CREMATION, REMOVAL (SPECIFY)	CEMETERY OR CREMATORY—NAME		LOCATION CITY OR TOWN STATE			
24b. <u>Burial</u>	24c. <u>Hillview Gardens</u>		24d. <u>Farmington, Missouri</u>			
DATE (MONTH, DAY, YEAR)	FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)					
24e. <u>May 22, 1970</u>	24f. <u>Wilson Funeral Home</u>		<u>Fredericktown, Missouri 63645</u>			
FUNERAL DIRECTOR—SIGNATURE			REGISTRAR—SIGNATURE	DATE RECEIVED BY LOCAL REGISTRAR		
25a. <u>[Signature]</u>			25b. <u>[Signature]</u>	25c. <u>May 22, 1970</u>		

Type or print in PERMANENT BLACK INK. See handbook for instructions.

JUN 8 - 1970

JUL 15 1970

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 Raymond B. Wilson

Licensed Embalmer No. 4984

P. O. Address Fredrickton MS

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.