

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.
H. Knish

26991

1. PLACE OF DEATH

County *Greene*

Registration District No. *318*

File No.

Township *Springfield*

Primary Registration District No. *2001*

Registered No. *589*

City *Springfield* (No. *2225 N. Campbell*)

St. *Springfield* (Ward) *6*

St. *Springfield* (Ward) *6*

2. FULL NAME

Annal May Hendrickson

(a) Residence. No. *2225 N. Campbell* St., *Springfield* Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Orland H. Hendrickson*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 28-1876*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
31 7 1

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *House wife* (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ark.*

10. NAME OF FATHER *Lock Kirksey*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *La.*

12. MAIDEN NAME OF MOTHER *Norah Hornsby*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *La.*

14. INFORMANT *Orland H. Hendrickson* (Address) *Springfield, Mo.*

15. FILED *9/30 27* REGISTRAR *O. O. Horst*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9/29 1927*

17. I HEREBY CERTIFY, That I attended deceased from *9-22-1927* to *9-29-1927* that I last saw him alive on *9/28-1927* and that death occurred, on the date stated above, at *9/28-1927* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastric Carcinoma

440 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH. *no*

WHAT TEST CONFIRMED DIAGNOSIS. *Microscopical lymph*

(Signed) *Wm. F. Smith* M. D. (Address) *500 1/2 E. Blvd*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Green Lawn Cemetery* DATE OF BURIAL *Sep 30 1927*

20. UNDERTAKER *W. H. Kingner Co 424* ADDRESS *Springfield, Mo*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT RECORD

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