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

Do not use this space.

34247

File No. .....

Registered No. 69

1. PLACE OF DEATH

County: Lafayette

Township: Dover

City: Longsdorf Home (No. ....., ... St. ..... Ward)

Registration District No. 466

Primary Registration District No. 5623-B

2. FULL NAME George Washington Hendrix

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF Unknown.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 24 1847

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	82	7	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Shaubburg
(STATE OR COUNTRY) Tenn

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT G. B. Harman Supt.
(Address) Longsdorf Home Mo

15. FILED 10-5-29 Rosie P. Porter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-5 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Oct 5, 1929, that I last saw him alive on Oct 5, 1929, and that death occurred, on the date stated above, at 5:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Hepatitis
93c

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chr. Pain in Bowels

(duration) yrs. 6 mos. ds.

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

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) L. DeWoin Hayes, M. D.

, 19 (Address) Higginsville Mo

*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 Con Home — DATE OF BURIAL 10/5 1929

20. UNDERTAKER Ashbaker — ADDRESS Higginsville Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—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.