

JAN 19 1938

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

Do not use this space.

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1. PLACE OF DEATH

County Johnson Registration District No. 429
Township Washington Primary Registration District No. 425-5
City Knob Noster Mo St. _____ Ward _____

2. FULL NAME Altha Hendrick

(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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED Widowed by Ed Hendrick
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept-17-1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 3 10

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 26

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

13. NAME Levi W. Shawhan

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

15. MAIDEN NAME Mary Fridley

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Rolla Hendrick
Knob Noster Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Knob Noster DATE Dec-29-1937

19. UNDERTAKER (ADDRESS) C. L. South
Knob Noster Mo.

20. FILED Dec 26 1937 J. A. Koch Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 27 1937

22. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1937, to Dec 27, 1937

I last saw her alive on Dec 27, 1937 Death is said

to have occurred on the date stated above, at 8:00 p. m.

The principal cause of death and related causes of importance were as follows:

① Valvular disease Date of onset

② Cholera

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? Clinical as there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____ (Signed) H. W. Proove, M. D.

(Address) Knob Noster, Mo

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.

