

1939 APR 11 1939

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

10378
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Co. Registration District No. 130
(b) Township Wales Primary Registration District No. 5125
(c) City Randles (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mary Hendrickson
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 HUSBAND OF (OR) WIFE OF Josephus Hendrickson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 23, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 3 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
9. Industry or business in which work was done, as saw mill, bank, etc. _____
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) Saline Co. Illinois

FATHER 13. NAME Cross

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

MOTHER 15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT (ADDRESS) Mrs Pearl Schlosser Randles Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Fairview Cem Cape Co. Mo. DATE 4/6/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Buppelhoff Hubball Chaffee Mo.

20. FILED Mar 5 1939 Mrs Wm Sichel Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/5 1939

22. I HEREBY CERTIFY, That I attended deceased from 1/20 1939, to 4/5 1939

I last saw him alive on 4/1 1939. Death is said to have occurred on the date stated above, at 3 a m.

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

Asphyxiation
Vascular Hypertension
Date of onset 4/4/39

Other contributory causes of importance: ?

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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? Yes
If so, specify _____
(Signed) P. P. Casner, M. D.
(Address) Chaffee 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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ~~embalmed~~ ^{prepared} by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Marnie Duplenghoff
Licensed Embalmer No. 3242
P. O. Address Chaglee M

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 this body is not embalmed, above space should be left blank.