

MAY 12 1939

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

14415

Do not use this space.

## 1. PLACE OF DEATH

(a) County CARLAWAY Registration District No. 104  
(b) Township \_\_\_\_\_ Primary Registration District No. 3058  
(c) or City FULTON (d) Street No. \_\_\_\_\_ Registered No. 112  
(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

536 EDWARD P. HENDERSON  
(a) Residence, No. 612 Bluff St. Fulton Mo. (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF MINNIE (JATHO) HENDERSON

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) SEPT. 3, 1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
87 7 9

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. RETIRED FARMER

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) CARLAWAY COUNTY MISSOURI

13. NAME DAVID HENDERSON

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

15. MAIDEN NAME MARY BLACKBENBURG

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

17. INFORMANT (ADDRESS) WALTER HENDERSON FULTON, MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE MC. CARMEL DATE APR. 14, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Glenn Y. Maupin 700 Court St. Fulton, Mo.

20. FILED April 19, 1939 P. N. Craves Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 12, 1938 to April 12, 1939

I last saw him alive on April 12, 1939. Death is said to have occurred on the date stated above, at 1:30 p.m.  
The principal cause of death and related causes of importance were as follows:

Arterio Sclerosis

Date of onset

Other contributory causes of importance:

Infected Prostate gland

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Chinica Was 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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) R. N. Craves, M. D.

(Address) Fulton 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!

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**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

John D. Batchelder, Registered Apprentice No. 192  
working under my personal supervision.

Signed Glen Y. Maupin  
Licensed Embalmer No. 2725  
P. O. Address Fulton, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

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

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

14415-  
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104  
(b) Township Fulton Primary Registration District No. 3008 Registered No. \_\_\_\_\_  
(c) City Fulton (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 Eduard P. Henderson

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid  
(write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
87 7 9

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

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED June 11, 1939 P. N. Crews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-12-1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_

I last saw him alive on \_\_\_\_\_, 19\_\_ Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

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

arteriosclerosis Date of onset \_\_\_\_\_

Other contributory causes of importance:

enlarged Prostate gland  
Hypertension

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? \_\_\_\_\_

If so, specify

(Signed) P. N. Crews, M. D.  
(Address) Fulton Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

