

35 JUL 24 1939

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

23112
Do not use this space.

1. PLACE OF DEATH
 (a) County H. Clair Registration District No. 765
 (b) Township 1 Primary Registration District No. 4460 Registered No. 12
 (c) City Osceola (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 Herbert F. Henderson Sr.
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clara E. Grek
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 13-1871
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 67 8 23
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired P.O.
 9. Industry or business in which work was done, as saw mill, bank, etc. Employee
 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) Mich

FATHER 13. NAME Lewis Henderson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mich

MOTHER 15. MAIDEN NAME Nina Cuddy
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mich

17. INFORMANT (ADDRESS) Mrs. F. F. Henderson Long Beach, Calif.

18. BURIAL, CREMATION OR REMOVAL PLACE St. C. No. Mt. Washington DATE 6-8 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Osceola Mo.

20. FILED July 21, 1939 Herbert F. Henderson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-5-1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 1939, to _____, 19____. I last saw him Dead when I arrived 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:

Heart trouble Date of onset _____

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? _____
 If so, specify _____
 (Signed) E. H. Sullivan M.D.

(Address) Osceola 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.

2002

RECEIVED

District Health Officer No. 7,

District File Number 7-39-1077

Date Filed 7-21-39

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, O. S. Hullif

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

Licensed Embalmer No. 2097

P. O. Address Oscola Mo.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH: (a) County St. Clair Registration District No. 765
 (b) Township..... Primary Registration District No. 4460 Registered No. 12
 (c) City Osceola (d) Street No. (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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 Herbert F. Henderson Sr.
 (a) Residence, No. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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.
67 8 23

OCCUPATION 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)

FATHER 13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 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 19

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-5-1939

22. I HEREBY CERTIFY, That I attended deceased from X 1939 to Aug 4, 1939.
 I last saw h. X alive on X 1939. Death is said to have occurred on the date stated above, at X m.
 The principal cause of death and related causes of importance were as follows:
Heart trouble Date of onset

He was a tourist from the state of California; 4 or 5 hours when he died on his car. He has had the disease for several years. The history obtainable from wife was as above stated. I would say possibly he had

Name of operator initial disease Date of
 What test confirmed diagnosis? X Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No Date of injury X, 1939
 Where did injury occur? No injury (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place
He was here to fish a few
 Manner of injury day
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify T. W. Sullivan M. D.
 (Signed) Osceola Mo.
 (Address) Aug 4 - 1939

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.

Local Registrar.

