

Registration District No. 200Primary Registration District No. 4120Registrar's No. 11

1. PLACE OF DEATH:

- (a) County Clay 2
 (b) City or town Kearney
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____
 (Specify whether _____)

In this community
years, months or days3. (a) PRINT FULL NAME Alcepha S. Henderson 5363. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex Female5. Color or
race White6. (a) Single, widowed, married
divorced Widowed6. (b) Name of husband William S. Henderson6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased
(Month) April30 1858
(Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

815-

hr. _____ min.

9. Birthplace

(City, town, or county)

Missouri
(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

12. Name Shelton Brown 113. Birthplace Kentucky
(City, town, or county) (State or foreign country)14. Maiden name Frances Bennett15. Birthplace Kentucky
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Ruth Henderson(b) Address Kearney, Missouri17. (a) Burial (b) Date thereof Oct 2 1939
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Fairview Cem. Kearney18. (a) Signature of funeral director Leonard F. ...(b) Address Kearney, Missouri19. (a) 10/2/39 (b) Phos. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 5(c) City or town _____
(If outside city or town limits, write "RURAL")(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
year 1939 hour 1 minute 30 P. M.21. I hereby certify that I attended the deceased from 1936
_____ 19____, to Sept 30 1939;that I last saw her alive on 9-28 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma of stomach

Duration

2 yrs.

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations noneOf autopsy none

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature N. R. Schumacher (M. D. or other) M.D.Address Kearney Mo Date signed 10-2-39

RECEIVED
District Health Officer No. 8
10/11/39

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, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Leonard Fry
Licensed Embalmer No. 1677
P. O. Address Kearney Ind

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.

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

32192

Do not use this space.

1. PLACE OF DEATH
- (a) County Clay Registration District No. 200
- (b) Township Keasney Primary Registration District No. 4120 Registered No. 11
- (c) City Keasney (d) Street No. _____ 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 Alcepha S. Henderson
- (a) Residence, No. Keasney, Mo. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid
- 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. |
|--------|-----------|----------|----------|----------------------------------|
| | <u>81</u> | <u>5</u> | <u>-</u> | |
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 10/2/39 19 Chas. L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 30 19 39
22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.
- I last saw h_____ 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:
- 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) J. R. Schumacher M. D.
- (Address) Keasney, Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THE ABOVE IS COMPLETED AS PER INSTRUCTIONS

SUPPLEMENTARY

