

Registration District No. 19

Primary Registration District No. 5036

Registrar's No.

1. PLACE OF DEATH:

- (a) County Adair Salina
- (b) City or town _____
- (c) Name of hospital or institution: Salina Sppt 2
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution _____ (Specify whether
years, months or days) 30 days
- In this community _____
years, months or days) 8 1/2

3. (a) PRINT FULL NAME DELL HENNE BERRY

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Mar 1 1973
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 8 22 hr. min.9. Birthplace Minnesota
(City, town, or county) (State or foreign country)10. Usual occupation None11. Industry or business None12. Name Rodger Henneberry13. Birthplace U.S.
(City, town, or county) (State or foreign country)14. Maiden name Mary Ann Ryan15. Birthplace Ireland
(City, town, or county) (State or foreign country)16. (a) Informant's name Joe Henneberry(b) Address Centralia Mo 13 St17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Woodward Oklahoma18. (a) Signature of funeral director mommet(b) Address Centralia Mo19. (a) Nov. 24, 1939 (b) adbroth 4:5
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Oklahoma (b) County _____
- (c) City or town Woodward
(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 Nov day 23
year 1939 hour 7 minute 30 A M.21. I hereby certify that I attended the deceased from 11/22/39, 19____, to 11/23/39, 19____;
that I last saw her alive on 11/24/39, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death Total pneumonia Duration 11/3

Due to _____

Due to _____

Other condition: Possibly stroke
(Include pregnancy within 3 months of death)
with influenzaMajor findings:
Of operations _____

Of autopsy _____

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 adbroth (M.D. or other)Address Centralia Mo Date signed 11/24/39

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 _____

Licensed Embalmer No. _____

P. O. Address. _____

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.