

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40507
Registrar's No. 125

Registration District No. 677

Primary Registration District No. 4403

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

1. PLACE OF DEATH
(a) County Phelps
(b) City or town Rolla Mo.
(c) Name of hospital or institution McFarland Hospital
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
In this community 18 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Glen Henson F. 5
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 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 Oct. 5- 1929
(Month) (Day) (Year)

8. AGE: Years 10 Months 1 Days 10 If less than one day hr. min.

9. Birthplace Phelps County Mo. D
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business _____

12. Name James Henson

18. Birthplace Phelps County, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Agnes Hucker

15. Birthplace Phelps Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James Henson

(b) Address Bellevue Missouri

17. (a) Burial (b) Date thereof Nov. 18-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Patrol Knob Mo

18. (a) Signature of funeral director Joe Johnson

(b) Address Newburg Mo

19. (a) Nov. 18, 1939 (b) Joe F. Lyons
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Phelps
(c) City or town Newburg
(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 15, year 1929 hour 8 minute 30 P. M.
21. I hereby certify that I attended the deceased from Oct 23rd, 1929, to Nov 15th, 1929; that I last saw him alive on Nov 15, 1929; and that death occurred on the date and hour stated above.

Immediate cause of death Injury (intestinal) to the sigmoid flexure of colon
Due to abraded severe bruise to the cecum and appendix
Due to Fall on a wood saw handle. Oct 19, 1929
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Appendectomy
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Oct 19, 1929
(c) Where did injury occur? Newburg Phelps Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? on farm

While at work? Yes (Specify type of place) fall on saw
Type of injury fall on saw

28. Signature Dr. Henry Metcalf (M. D. or other) M.D.
Address Rolla Mo Date signed 11-13-29

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.

RECEIVED

District Health Officer No. 5,

License Number 1239582

Issued 12/339

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.