

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.

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

2470
Do not use this space.

1. PLACE OF DEATH

(a) County Grundig Registration District No. 327
 (b) Township Galt Primary Registration District No. 4194 Registered No. 1
 (c) City Galt (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

Sylvia Pearl Hensenflow
 (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 Female 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 12, 1901

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>38</u>	<u>8</u>	<u>29</u>	

OCCUPATION

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

9. Industry or business in which work was done, as saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year) 12-31-29 11. Total time (years) spent in this occupation 21

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harris Mo RFD.

FATHER

13. NAME Wm. Anderson

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

MOTHER

15. MAIDEN NAME Rose Waltemier

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

17. INFORMANT (ADDRESS) E. G. Hensenflow Galt Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Salem Cem. Galt Mo DATE Jan 14, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. Payne Son Galt Mo

20. FILED 1-11-1940 E. C. Weston Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 11, 1940

22. I HEREBY CERTIFY, That I attended deceased from 12-31-1939, to 1-11-1940
 I last saw her alive on 1-10-1940 Death is said to have occurred on the date stated above, at 10:45 a. m.
 The principal cause of death and related causes of importance were as follows:
Broncho pneumonia
146
 Other contributory causes of importance:
Acute nephritis & Cardiac dilatation at childbirth
 Name of operation none Date of _____
 What test confirmed diagnosis clinical 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? no
 If so, specify _____
 (Signed) W. C. Weston, M. D.
 (Address) Galt Mo

Date of onset 1-9-40

RECEIVED

District Health Officer No. 11,
District File Number 240-19
Date Filed FEB 3 1940

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.