

MAY 15 1940

317-4192

Registration District No. _____

Primary Registration District No. 317

Registrar's No. 4192

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene
(c) City or town Republic
(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 May day 10
year 1940 hour 8 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on May 10, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Slashed Throat (Suicide)

Due to _____
Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
Of autopsy: _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Suicide
(b) Date of occurrence May 10, 1940
(c) Where did injury occur? Republic Greene Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
204 Home

(Specify type of place)
While at work? No (e) Means of injury Reps
23. Signature R. M. White (M. D. or other) _____
Address Greene County Date signed 5/10/40

8. (a) PRINT FULL NAME William Riley Hendricks
536
3. (b) If veteran, name war _____ 3. (c) Social Security No. 500-098614

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Stella Hendricks 6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased Sept 17 - 1885
(Month) (Day) (Year)

8. AGE: Years 52 Months 7 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation H.P.A. Laborer

11. Industry or business _____

12. Name Bennet Hendricks
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name Mary Lafollette
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Waldo Hendricks
(b) Address 635 Park Ave. Springfield
17. (a) Burial (b) Date thereof May 11-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Kerr Chapel

18. (a) Signature of funeral director W. M. ...
(b) Address Clewer Mo
19. (a) May 10 (b) W. M. Bertha Naiser
(Date received local registrar) (Registrar's signature)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

J.W. Maple

Licensed Embalmer No. *2985*

P. O. Address *Clever, 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.