

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.

Registration District No. **437**

Primary Registration District No. **5594**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jahson

(b) City or town Rose Hill Rural Rose Hill
(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 2
(Specify whether _____)

In this community 30 years
years, months or days

8. (a) PRINT FULL NAME Patrick Henry 560

8. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Leona Maude Henry

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased February 26 1861
(Month) (Day) (Year)

8. AGE: Years 79 Months 1 Days 11
If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Thompson Henry D

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Mary Young

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Ellis F. Henry

(b) Address Latur Mo. R.F.D. #1

17. (a) Burial (b) Date thereof Apr 19-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garden City Cemetery

18. (a) Signature of funeral director W. E. ...

(b) Address ...

19. (a) April 8 (b) ANNA COLEMAN
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jahson

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Latur _____
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7
year 1940 hour 5:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from April 6
1940 to April 7 1940
that I last saw him alive on April 7 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 12 hr

Due to chr. mitral stenosis 6 yrs

Due to _____

Other conditions none
(Include pregnancy within 8 months of death)

Major findings: none

Of operations no

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(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? no

(e) Means of injury _____
(Specify type of place)

23. Signature W. E. ...
Address Garden City Mo

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-15-10

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 *W. G. Jordan*
Licensed Embalmer No. *2424*
P. O. Address *Holden 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.