

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15434

State File No. _____

Registration District No. 529

Primary Registration District No. 5705

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Macon Missouri
(b) City or town Rural
(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 _____
(Specify whether _____)
In this community _____
years, months or days 536

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon
(c) City or town Rural
(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.

3. (a) PRINT FULL NAME MARGARETTE URTON HENDRICKS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Hendricks 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 14 1882
(Month) (Day) (Year)

8. AGE: Years 58 Months 9 Days 25
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Jackson Hotel

12. Name Joseph Maherton

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

14. Maiden name Sarah Carter

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

16. (a) Informant's own signature William Hendricks
(b) Address Jacksonville, Mo

17. (a) Burial (b) Date thereof Apr. 11 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Jacksonville

18. (a) Signature of funeral director Tom B. Patton
(b) Address Jacksonville, Mo

19. (a) May 4 1940 (b) Mrs R. W. Powell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9
year 1940 hour 11 minute 0 M.

21. I hereby certify that I attended the deceased from March 27, 1940, to April 9, 1940:

that I last saw her alive on April 9, 1940:
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia & Rheumatic Heart has been in Poor Health for 1 yr.

Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy no

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) X
(b) Date of occurrence X
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 47?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature J. Strippeer (M. D. or other) _____
Address College mound Mo Date signed 4-15-1940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.

9582

RECEIVED

District Health Officer No. 10

District File Number 5-40970

Date Filed MAY 9 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 Paul J. Patton

Licensed Embalmer No. 4025

P. O. Address Huntsville, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-434

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 529

Primary Registration District No. 5700

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Chariton T.P.
(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 _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

3. (a) PRINT FULL NAME Margarette Burton Hendricks

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 58 Months 9 Days 25 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

CERTIFICATION

20. DATE OF DEATH Month Apr day 9 year 1990 hour _____ minute _____ M.

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

Immediate cause of death Pneumonia and Rheumatic Heart has been in poor health for

Due to 1 yr

Due to Lobar pneumonia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

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) _____

(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 F. L. Triffes (M. D. or other)

Address College mound Mo Date signed _____

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 157434

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. 229

Primary Registration District No. 3705

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Chariton
(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
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town.....
(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.

3. (a) PRIMARY FULL NAME Margarette Weston Henderson
3. (b) If veteran, name war..... 3. (c) Social Security No.....

20. DATE OF DEATH Month Apr day 4 year..... hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 19..... to..... 19..... that I last saw him alive on..... 19..... and that death occurred on the date and hour stated above.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years
7. Birth date of deceased June 14 - 1888
(Month) (Day) (Year)

Immediate cause of death.....
Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause to which death should be charged statistically.

8. AGE: Years 57 Months 3 Days 20 If less than one day hr..... min.....

9. Birthplace..... (City, town, or county) (State or foreign country)
10. Usual occupation.....
11. Industry or business.....
MOTHER FATHER { 12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....
17. (a) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....
18. (a) Signature of funeral director..... (b) Address.....

19. (a) May 4, 1900 (b) Mrs R. W. Dowell
(Date received by registrar) (Registrar's signature)

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) (c) Means of injury.....
23. Signature..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTAL