

FILED AUG 19 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28377**

Registration District No. **247**

Primary Registration District No. **247-5342**

Registrar's No. **15**

1. PLACE OF DEATH:

(a) County **Dallas** **FILED SEP 19 1940**

(b) City or town **Rural Washington**
(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) **2**

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days **125**

3. (a) PRINT FULL NAME **Wilbur Gene Henson**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **M**

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 **June 1 1940**
(Month) (Day) (Year)

8. AGE: Years _____ Months **2** Days **8** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name **Calvin Henson**

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

14. Maiden name **W. J. Jiguel**

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

16. (a) Informant **Calvin Henson**

(b) Address **Phillipsburg Mo.**

17. (a) **Rural** (b) Date thereof **8-9-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt Zion**

18. (a) Signature of funeral director **S. B. Jones**

(b) Address **Phillipsburg Mo.**

19. (a) **9-10-40** (b) **S. J. Salvo**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Dallas**

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

(d) Street No. **Phillipsburg Mo.**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **8**
year **1940** hour **6** minute **P** M.

21. I hereby certify that I attended the deceased from **8-7-40**
5 30 - **1940**, to _____, 19____;
that I last saw him alive on **8-7**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Stomach meningitis
with **ulcer colitis**

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) **11/10**

Major findings:
Of operations _____
Of autopsy _____

Duration _____
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? **2011**

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

23. Signature **W. H. Lindsey** (M. D. or other) _____

Address **Phillipsburg Mo.** Date signed _____

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

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1329

Date Filed 9-13-40

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.