

FILED OCT 12 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31356

Registration District No. 47

Primary Registration District No. 5103

Registrar's No.

1. PLACE OF DEATH:

(a) County Bollinger
(b) City or town Rural Crooked Creek
(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) no
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life time years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bollinger
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Marguerite A.R. # 1
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17th
year 1940 hour 11:00 minute 55 P.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 Chronic Dehydration
Complications of Dehydration

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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? _____
(Specify type of place) _____

(e) Means of injury _____

23. Signature Dr. Archer J. Baird
Address Fort Tompkins, Mo. Date signed _____

3. (a) PRINT FULL NAME JUAN FERNANDEZ HENDERSON

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased July 11, 1862
(Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name James Henderson

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

14. Maiden name Mrs. Short

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

16. (a) Informant's own signature M. Henderson

(b) Address Marguerite A.R. # 1

17. (a) Rural (b) Date thereof Aug 16, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Carmel

18. (a) Signature of funeral director Baker Funeral Home

(b) Address Lutsumiller, Mo. S. B. Graham

19. (a) 10/12/1940 (b) _____
(Date received local registrar) (Registrar's signature)

WRITE FULLY IN 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.

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.....

James Ferdinand Henderson, Registered Apprentice No. *4010*
working under my personal supervision.

Signed *J E Graham*

Licensed Embalmer No. *4010*

P. O. Address *Subsally 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.