

Registration District No. 408

Primary Registration District No. 3020

Registrar's No. 178

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
McCune - Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days
(Specify whether years, months or days)
In this community 20 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Carthage
(If outside city or town limits, write "RURAL")
(d) Street No. 1129 So. Main St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 18th
year 1940 hour 4:17 minute P.M.

21. I hereby certify that I attended the deceased from May 19, 1935, to Sept 18, 1940;
that I last saw him alive on Sept 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Gastric hemorrhage 19 hrs.

Due to Carcinoma stomach 3 yrs.

Due to 4/6

Other conditions Hypertensive Nephritis 5 yrs.
(Include pregnancy within 6 months of death)

PHYSICIAN
Major findings: none
Of operations: none
Of autopsy: none
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Clara Henrichs

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

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

7. Birth date of deceased June 7, 1854
(Month) (Day) (Year)

8. AGE: Years 86 Months 3 Days 11 hr. _____ min. If less than one day

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Michiel Wahrer

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

14. Maiden name Gertrude Hipp
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Miss Netta Henrichs

(b) Address 1129 So. Main St., Carthage, Mo.

17. (a) Burial (b) Date thereof 9-20-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Ed. C. Ulmer

(b) Address 1208 S. Garrison, Carthage, Mo.

19. (a) 9/19/40 (b) [Signature]
(Date received local 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?
65 (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) M.D.
Address Carthage, Mo. Date signed 9/19/40

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. 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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Edle...*

*Licensed Embalmer No. *2222*

P. O. Address *Carthage*

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, above space should be left blank.