

No. 2
-11-10-30
5-17-30
PI X21432

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36639

State File No.

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 274

1. PLACE OF DEATH:

(a) County VERNON
(b) City or town NEVADA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
STATE HOSPITAL NO 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3
In this community 1 year 5 months 27 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DALLAS
(c) City or town BUFFALO
(If outside city or town limits, write "RURAL")
(d) Street No. UNKNOWN
(If rural, give location)
(e) If foreign born, how long in U. S. A? U.S.A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31
year 1940 hour 10 minute 10 P.
21. I hereby certify that I attended the deceased from
Oct, 1939, to Oct 31, 1940
that I last saw him alive on Oct 31, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
CHRONIC MYOCARDITIS
Due to _____
Due to _____

Other conditions: ARTERIOSCLEROSIS -
(Include pregnancy within 3 months of death) SENILITY
FINE FRACTURE NECK OF FEMUR
Major findings: (NO DISPLACEMENT)
Of operations: NONE
Of autopsy: NONE

Duration
PHYSICIAN
Underline
(the cause to
which death
should be
charged sta-
tistically.)

8. (a) PRINT FULL NAME THOMAS HENDRICKSON
8. (b) If veteran, name war No. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife NONE 6. (c) Age of husband or wife if alive NONE years
7. Birth date of deceased UNKNOWN
(Month) (Day) (Year)

8. AGE: Years about 74 Months Days If less than one day
hr. min.

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

10. Usual occupation FARMER

11. Industry or business NONE

MOTHER FATHER { 12. Name SAMUEL HENDRICKSON
13. Birthplace DALLAS CO, MISSOURI (City, town, or county) (State or foreign country)
14. Maiden name FRANCES SHEEK
15. Birthplace DALLAS CO. MISSOURI (City, town, or county) (State or foreign country)

16. (a) Informant RECORDS STATE HOSP #3
(b) Address NEVADA MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-40 (Month) (Day) (Year)
(c) Place: burial or cremation Buffalo, Mo.

18. (a) Signature of funeral director H. B. Jones
(b) Address Buffalo, Mo.

19. (a) 11-1-40 (Date received local registrar) (b) Allen V. Hays (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ACCIDENT - FALL ON WARD
(b) Date of occurrence OCT 1, 1940

(c) Where did injury occur? NEVADA VERNON MO. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
WARD STATE HOSP #3

While at work? No. (Specify type of place) FRACTURE
(e) Means of injury (SEE ABOVE)

23. Signature Paul L. Barone (M. D. or other) MD
Address STATE HOSP #03 Date signed Oct 31

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

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RECEIVED

District Health Officer No. 7,

District File Number 11-40-1540

Date filed 11-4-40

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.