

Registration District No. 65

Primary Registration District No. 4390

1. PLACE OF DEATH:  
(a) County Jenison  
(b) City or town Hays  
(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 3 (Specify whether  
In this community 3 years, months or days)

8. (a) PRINT FULL NAME Lera Hendrick  
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years 18 1/2  
7. Birth date of deceased Nov. 7 (Month) (Day) (Year)

8. AGE: Years 67 Months 2 Days 2 If less than one day hr. 1 min. 1

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

10. Usual occupation housewife

11. Industry or business  
MOTHER FATHER { 12. Name Allen Watson  
13. Birthplace Moulton N.C. (City, town, or county) (State or foreign country)  
14. Maiden name Russell Watson  
15. Birthplace N.C. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ed C. Balbo  
(b) Address Hays, Mo.

17. (a) Removal (b) Date thereof Jan 10, 1941 (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Croghan S.C.

18. (a) Signature of funeral director Ray W. Co.  
(b) Address Mo.

19. (a) 1/10/41 (Date received local registrar) (b) Pearl Kelley (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State S.C. (b) County Cherokee  
(c) City or town Mt. Croghan (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. 2 years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 9th year 1941 hour 5 P.M. minute \_\_\_\_\_ M. \_\_\_\_\_  
21. I hereby certify that I attended the deceased from Dec 23, 1940, to Jan 9, 1941; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Spasmodic Paralysis (Type undetermined) Duration 1 1/2 yrs  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) Jaundice

Major findings: Of operations none  
Of autopsy none  
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 Ed C. Balbo (M. D. or other) MD  
Address Cherokee, S.C. Date signed 1/10/41

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.

**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 Jack Kelley

Licensed Embalmer No. 3788

P. O. Address Hayt. 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.**