

FILED FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4527

84
~~6063~~ 814

Primary Registration District No. 6063

Registrar's No. 5

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Benton Rural
(c) Name of hospital or institution:
County Farm 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

8. (a) PRINT FULL NAME JOHN HENLEY
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 Widower
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years 77 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation unknown

11. Industry or business _____

MOTHER FATHER
12. Name unknown
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. C. Merickson
(b) Address Benton Mo.

17. (a) Burial (b) Date thereof 1-25-41 (Month) (Day) (Year)
(c) Place: burial or cremation Benton Mo.

18. (a) Signature of funeral director P. A. Dresser/Boff
(b) Address Oran Missouri

19. (a) 1-25-41 (b) Symon Soule (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Scott
(c) City or town Benton Rural (If outside city or town limits, write "RURAL")
(d) Street No. Co Farm (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24th year 1941 hour 7 minute 04 P. M.
21. I hereby certify that I attended the deceased from Jan 1, 1941, to Jan 22, 1941
that I last saw him alive on Jan 22, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death: Cystitis Pharyngitis Acute Retention Urine Duration 1 mo
Due to Senility America 2 Day

Due to Probable Carcinoma
Other conditions Throat & Prostate & Kidney

Major findings: _____
Of operations _____
Of autopsy _____

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? _____

23. Signature W. D. Sumner (M. D. or other) _____
Address 344 Bell Chaffee Mo Date signed 1/25/41

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

Rev. 5-17-39 I 119511

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

46

RECEIVED

District Health Officer No. 2

District File Number 241-198

Date Filed 2/10/41

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 45-27

Registration District No. 814

Primary Registration District No. 6063

Registrar's No. _____

1. PLACE OF DEATH

(a) County Scott
(b) City or town Moreland T.P.
(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)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME John Henley
3. (b) If veteran _____ 3. (c) Social Security No. _____
name war _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 77 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24
year 1944 hour _____ minute _____ 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 Cephalic Pharyngeal Angitis Duration _____

Due to acute retention of urine

Due to Anuria, Senility

Other conditions Probable Carcinoma
(Include pregnancy within 3 months of death)

Major findings: throat and prostate PHYSICIAN _____
of Kidneys

Of autopsy Probable Prognosis Underline the cause to which death should be charged statistically. Very uncertain

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 W. D. ... (M. D. or other _____)

Address Chaffee Mo Date signed 1/24/44

SUPPLEMENTARY 458

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

100-10000

