

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4711

Registration District No. 875 Primary Registration District No. 6162 Registrar's No. 13

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Washington Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 3 Nevada, Mo 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr, 10 mos & 14 days
(Specify whether)

(c) PRINT FULL NAME RALPH NOEL HENDRIX

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs Corda Anis Hendrix 6. (c) Age of husband or wife if alive Not known years
7. Birth date of deceased August 6th 1888
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days 8 If less than one day hr. _____ min. _____

9. Birthplace 1 Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business _____

MOTHER FATHER { 12. Name O.P. Hendrix
13. Birthplace Not known 9
(City, town, or county) (State or foreign country)
14. Maiden name Ida Fouts
15. Birthplace Ida Fout 1. Not known 9
(City, town, or county) (State or foreign country)

16. (a) Informant State Hospital Records
(b) Address Nevada, Mo

17. (a) Burial (b) Date thereof 1-16-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reeds Cemetery

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

(b) Address Carthage, Mo.

19. (a) 1-14-41 (b) Allen V. Hays
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jasper 108
(c) City or town Carthage 0
(If outside city or town limits, write "RURAL")
(d) Street No. 606 East 3rd St. 0
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14th
year 1941 1 hour 45 minute P.M.

21. I hereby certify that I attended the deceased from March 1939 to Jan 14th 1941;
that I last saw him alive on Jan 13th 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Meningo Vascular Les. Duration ?

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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

22. If death was due to external causes, fill in the following: 2

(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? 795

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G.S. Waraich (M. D. or other) 1

*Address State Hospital No 3 Nevada Date signed 1/14/41

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

RECEIVED

District Health Officer No. 7,

District File Number 2-41-215

Date Filed 2-5-41

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.