

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18743

Registration District No. 709 Primary Registration District No. 5935 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Polk  
(b) City or town Bondo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution St. Elizabeth's  
(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 \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Polk 88  
(c) City or town Bondo Mo  
(If outside city or town limits, write "RURAL")  
Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country U.S.

3. (a) PRINT FULL NAME May Hendricks

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife Bill Hendricks 6. (c) Age of husband or wife if alive 27 years  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 23 Months 4 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation A. O. C.

11. Industry or business none

12. Name Andrew J. James

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

14. Maiden name Asaiah Mae Thompson

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof May 12, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Bondo cemetery

18. (a) Signature of funeral director Rayton Robert B. French

(b) Address Flemington

19. (a) May 11 1941 (Date received local registrar) (b) Dea. M. Locken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10th year 1941 hour 12:00 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from mech 1941 to mech 1941; that I last saw her alive on mech 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid fever Duration 9 wks

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations none

Of autopsy none

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 Rose C. Neims (M. D. or other) Chid

Address Humanville Mo Date signed 5-11-41

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

RECEIVED

District Health Officer No. 7,

District File Number 6-41-1015

Date Filed 6-11-41

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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.....

R. O. Address.....

**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, fact should be so stated above.**

B  
-41  
7852

Registration District No. 707

Primary Registration District No. 2938

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Dale  
(b) ~~City or town~~ Jefferson T. P.  
(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 Mary Hendricks

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_

7. Birth date of deceased (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years 23 Months 4 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10  
year 1941 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 \_\_\_\_\_

Typhoid fever 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:

(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 Roscoe C. Reins (M. D. or other) MD  
Address Humanville Mo Date signed 8-4-41

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

SUPPLEMENTARY

2B  
-41  
27852

Registration District No. 709

Primary Registration District No. 3938

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Polk  
(b) City or town Jefferson 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 May Hendricks  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year  
7. Birth date of deceased April 17, 1918  
(Month) (Day) (Year)

8. AGE: Years 23 Months 4 Days 23 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) May 11, 1941 (b) Veda Niebrochen  
(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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid fever 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:

(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 Roseve C. Newsome (M.D. or other)

Address Humanasville Date signed \_\_\_\_\_

SUPPLEMENTARY

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