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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25402

REC'D AUG 14 1941

Local Registrar's No. 19

Primary Registration District No. 4267

Registrar's No.

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

3
1
2

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution all of life (Specify whether
In this community 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 085 00
(a) State Mo (b) County Laclede
(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.? 1 years.

3. (a) PRINT FULL NAME Judith Ann Henderson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced W 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 13 (Day) 1941 (Year)
8. AGE: Years | Months | Days 22 | If less than one day hr. min.
9. Birthplace Lebanon (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name John D. Henderson
FATHER 13. Birthplace Grand Saline (City, town, or county) Texas! (State or foreign country)
MOTHER 14. Maiden name Faydene Fortune
MOTHER 15. Birthplace Grand Saline (City, town, or county) Texas! (State or foreign country)
16. (a) Informant Mrs. D Fortune
(b) Address
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/41 (Month) (Day) (Year)
(c) Place: burial or cremation Grand Saline Texas
18. (a) Signature of funeral director W. E. Holman
(b) Address Lebanon Mo
19. (a) 7-10-41 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6 year 1941 hour 3 minute P M.

21. I hereby certify that I attended the deceased from June 13, 1941, to July 6, 1941; that I last saw her alive on July 6, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Malnutrition 22 days
Due to embryological underdevelopment of ileum. No lumen present 22 days
Due to
Other conditions (Include pregnancy within 3 months of death) 158
Major findings: Of operations No lumen in ileum.
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature James L. Hope (M. D. or other) 4
Address Lebanon Date signed 7/8/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 8/41/1289
Date Filed 8/12/41

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 Myself, Registered Apprentice No. ..... working under my personal supervision.

Signed W. E. Holman

Licensed Embalmer No. 4107

P. O. Address Lebanon Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25 402

Registration District No. 449 Primary Registration District No. 4267 Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Pulaski
(c) City or town Waynesville (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Judith A Henderson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
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 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
12. FATHER Name
13. FATHER Birthplace (City, town, or county) (State or foreign country)
14. MOTHER Maiden name
15. MOTHER Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Judith Henderson
(b) Address Waynesville Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof 7-1-41 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 9-19-41 (Date received local registrar) (b) J E McCreech (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 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.

	Duration
Immediate cause of death	
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-25402