

FILLED OCT 15 1941

Registration District No. **135**

Primary Registration District No. **5192**

Registrar's No. **96**

1. PLACE OF DEATH:

(a) County **Carroll**
(b) City or town **Carrollton, RFD #3**
(c) Name of hospital or institution:
Home 5 miles N.W. Carrollton
(d) Length of stay: In hospital or institution **Since 1890**
In this community **Since 1890**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Carroll**
(c) City or town **rural - Trotter Twp.**
(d) Street No. **Carrollton, Mo. R.P. #30**
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **3rd**,
year **1941** hour **7:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **1836** to **Sept 3rd**, 19**41**
that I last saw him alive on **Aug 31**, 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis**

Due to **Senility**

Due to **838**

Other conditions **None**
(Include pregnancy within 6 months of death)

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(z) Means of injury _____

23. Signature **[Signature]** (M. D. or other) **O.**
Address **Carrollton, Mo.** Date signed **9-5-41**

Duration
Physician
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **JOHN W. HENDERSON.**

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 **Married**

6. (b) Name of husband or wife **Bertha A. Henderson** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **March 7th, 1865**
(Month) (Day) (Year)

8. AGE: Years **76** Months **5** Days **26** If less than one day hr. _____ min.

9. Birthplace **Georgetown, Ohio, Brown County**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business _____

MOTHER FATHER { 12. Name **Joseph L. Henderson**
13. Birthplace **Newcastle, Ind.**
14. Maiden name **Elizabeth E. Bercaw**
15. Birthplace **Brown County, Ohio**

16. (a) Informant **Bertha Henderson**
(b) Address **Carrollton, Mo.**

17. (a) **Burial** (b) Date thereof **Sept. 5th, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Powell**

18. (a) Signature of funeral director **Clifford W. Austin**
(b) Address **Tina, Missouri**

19. (a) **9-5-41** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-14-41

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 _____
Clifford W. Austin, _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Clifford W. Austin

Licensed Embalmer No. #3233.

P. O. Address Tina, Missouri.

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

State File No. 31282

Registration District No. 135

Primary Registration District No. 5192

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Cerrilton
(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)

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 _____

3. (a) PRINT FULL NAME

John W. Henderson

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

Bertha A. Henderson

6. (c) Age of husband or wife if alive

13 years

7. Birth date of deceased

Mar 7, 1865
(Month) (Day) (Year)

8. AGE:

Years 76 Months 5 Days 17
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)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

Analya

(b) Address

19. (a)

9-5-41
(Date received local registrar)

(b)

John Haskins
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH:

Month Sept Day _____
Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____

_____ 19____

that I last saw him _____ live on _____ 19____

and that death occurred on the date and hour stated above.

Immediate cause of death _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-31283 1941