

No. 9-4 17-39 X29484

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 37712

Registration District No. 37 Primary Registration District No. 5053 Registrar's No.

1. PLACE OF DEATH:  
(a) County: Barry  
(b) City or town: Washburn  
(c) Name of hospital or institution: Washburn Rt #1  
(d) Length of stay: In hospital or institution: 16 years  
In this community 16 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Mo. (b) County: Barry  
(c) City or town: Washburn Rt #1  
(d) Street No: Rt #1  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME: Alpha Agnes Henry  
(b) If veteran, name war: No  
(c) Social Security No: No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 7th  
year 1941 hour 5 minute P.M.

4. Sex: Female  
5. Color or race: White  
6. (a) Single, widowed, married, divorced: 9  
6. (b) Name of husband or wife: Jack Henry  
6. (c) Age of husband or wife if alive: 17 - 1894  
Birth date of deceased: Aug 17 - 1894

21. I hereby certify that I attended the deceased from Dec 5/41  
19 to Dec 7/41  
that I last saw her alive on Dec 7/41  
and that death occurred on the date and hour stated above.  
Immediate cause of death: My Heart - A.C. ✓

8. AGE: Years 47 Months 3 Days 20  
If less than one day hr. min.

Due to  
Due to  
Other conditions: (include pregnancy within 3 months of death)

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

10. Usual occupation: Housework

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

MOTHER FATHER

11. Industry or business:  
12. Name: William Harvey  
13. Birthplace: Dent, Knowlton  
14. Maiden name: Dent, Knowlton  
15. Birthplace: Dent, Knowlton

16. (a) Informant: Jack Henry  
(b) Address: Washburn, Mo.  
17. (a) Burial (b) Date thereof: 12-11-41  
(c) Place: burial or cremation: Roller Ament

18. (a) Signature of funeral director: Leon Funeral Home  
(b) Address: Cassville, Mo.  
19. (a) 12/10/41 (b) Freda Edena  
(Date received local registrar) (Registrar's signature)

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)  
23. Signature: R. A. Hurst, M.D. (M. D. or other)  
Address: Washburn, Mo. Date signed

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

RECEIVED

District Health Officer No. 2

District File Number 12,41-16

Date Filed 12, 12, 41

RECEIVED

District Health Officer No. 6,

District File Number 1241-1861

Date Filed DEC 15 1941

RECEIVED BY THE CLERK OF THE DISTRICT HEALTH OFFICER

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 Howard L. Haman  
Licensed Embalmer No. 4122  
P. O. Address Cassville, Mo.

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, fact should be so stated above.

STANDARD CERTIFICATE OF DEATH

State File No. 37712

Registration District No. 37

Primary Registration District No. 5053

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

1. PLACE OF DEATH:

(a) County Barry  
(b) City or town Washington  
(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 Alpha A. Henry  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1941 hour 5 minute 00 M.  
21. I hereby certify that I attended the deceased from last then to 24  
19 1941 and that death occurred on the date and hour stated above.  
that I last saw him alive on \_\_\_\_\_ 1941;  
Immediate cause of death \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Josephine 6. (c) Age of husband or wife if alive 57 years  
7. Birth date of deceased: Aug 17 (Month) (Day) (Year)

Duration \_\_\_\_\_  
Due to anti-meningitis  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 432  
Of autopsy \_\_\_\_\_

8. AGE: Years 47 Months 3 Days 3 (If less than one day \_\_\_\_\_ min.)

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

10. Usual occupation housewife

11. Industry of business household

12. Name Bill Henry

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

14. Maiden name Wannell

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

16. (a) Informant Jack Henry

(b) Address Washington, Mo.

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation 12-12-41

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

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

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

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 INK—BACK SIDE—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

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

