

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

DEC 22 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

39270

State File No. _____

Registration District No. 165

Primary Registration District No. 6266 4460

Registrar's No. 13

1. PLACE OF DEATH:
 (a) County St Clair
 (b) City or town Osceola, Tenn
 (c) Name of hospital or institution St Clair County Clinic
 (d) Length of stay: In hospital or institution 6 Hours
 In this community acc of Lake

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St Clair
 (c) City or town Roscoe Rural
 (d) Street No. P.O. Roscoe Mo
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME CECIL BARTON HENDRICKSON

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month October day 19
 year 1941 hour 7 minute 15 P.M.

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

21. I hereby certify that I attended the deceased from 1 P.M. on Oct. 19, 1941, to Oct. 19, 1941, that I last saw him alive on Oct. 17, 1941, and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

Immediate cause of death Acute nephritis Duration ?

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

7. Birth date of deceased April 28 1935
 (Month) (Day) (Year)

8. AGE: Years 6 Months 5 Days 21 hr. _____ min. _____

Due to _____
 Due to _____

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

Other conditions (Include pregnancy within 3 months of death) 130

10. Usual occupation None

Major findings: Of operations _____
 Of autopsy _____

11. Industry or business _____

12. Name Thomas B Hendrickson

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

14. Maiden name Grace Taylor

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

16. (a) Informant Grace Hendrickson
 (b) Address Roscoe Mo

17. (a) Buried (b) Date thereof 10-21-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director O.S. [Signature]
 (b) Address Osceola Mo

19. (a) 10-21-1941 (b) [Signature]
 (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 g

23. Signature Dr. Bernard Abel (M. D. or other) D.O.
 Address Osceola Mo. Date signed 10/21/41

RECEIVED

District Health Officer No. 7

District File Number 12-41-205

Date Filed 12-18-41

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. 2097

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, fact should be so stated above.