

FILED JAN 20 1942 73

Registration District No. _____

Primary Registration District No. _____

5-1-44 3066

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Boone Co.
 (b) City or town COTNAM BLVD - 7 MO.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Boone Co. Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Boone Co
 (c) City or town Perch
(If outside city or town limits, write "RURAL")
 (d) Street No. HARRISBURG. MO. RFD. O
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME WALTER HENNING

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

4. Male 5. Color or race white 6. (a) Single, widowed, married, divorced SINGLE
 6. (b) Name of husband or wife a 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct 14 - 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 2 11 hr. min.

9. Birthplace FAIRBANKS CO TEXAS
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business DONT KNOW

MOTHER FATHER { 12. Name John Henning
 13. Birthplace DONT KNOW
(City, town, or county) (State or foreign country)
 14. Maiden name PAULINE BOONE BOONE
 15. Birthplace DONT KNOW
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs T W Henning
 (b) Address HARRISBURG MO

17. (a) Burial (b) Date thereof 12-27-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HARRISBURG - Cem

18. (a) Signature of funeral director Parsons
 (b) Address COLUMBIA, MO

19. (a) 12-27-41 (b) Mrs H. Stoddard
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 25
 year 1941 hour 7.20 minute _____ A.M.

21. I hereby certify that I attended the deceased from 12-24-
 _____, 1941, to _____, 19____;
 that I last saw him alive on 12-24, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Gun Shot Wound Duration 1-24-41

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 H. Stoddard (M. D. or other)
 Address Harrisburg Mo Date signed _____

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

11-11-77
11-11-77
11-11-77

TM

11-11-77

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 *M. W. Whitman*.....

Licensed Embalmer No. *3893*.....

P. O. Address *Calumet*.....

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.

Registration District No. 73

Primary Registration District No. 3006

Registrar's No.

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(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 Walter Henning
3. (b) If veteran, name war 3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 25
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19.....
to 19.....
that I last saw him/her alive on 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death

4. Sex m 5. Color of 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

Duration
Due to gun shot wound
on in back occurred on street
Dec 24 was taken to Boon County Hosp
Other conditions where he died
(Include pregnancy within 3 months of death)

7. Birth date of deceased Oct 14 1869
(Month) (Day) (Year)
8. AGE: Years 72 Months 2 Days 10 If less than one day min.

Major findings:
Of operations 166
Of autopsy

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

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

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide (specify)
(b) Date of occurrence 11-24-41
(c) Where did injury occur? on side walk
(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)

18. (a) Signature of funeral director
(b) Address
19. (a) (b)
(Date received local registrar) (Registrar's signature)

While at work? (e) Means of injury
23. Signature J. G. Gullett (M. D. or other)
Address Farrarburg Mo. Date signed 2-7-42

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

SUPPLEMENTARY

