

S. No. 2
A-1-4-41
v. 5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6835

Registration District No. 403

Primary Registration District No. 2557

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Hickman Mills, Mo. RR #2
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
79th & Dundee Road / Brookview Inn
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community Since Apr. 1, 1941 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Hickman Mills, Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. 79th & Dundee Ho. RR #2
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Nellie E. Henry
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb. day 20
 year 1942 hour 1:40 PM minute _____ M.

4. Sex Female
 5. Color or race White
 6. (a) Single, widowed, married, divorced, married
 6. (b) Name of husband or wife James S. Henry
 6. (c) Age of husband or wife if alive 66 years
 7. Birth date of deceased Mar. 14 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12:30 am
2-19-42 19____ to 2-20-42 19____
 that I last saw her alive on 2-20-42 (10-PM)
 and that death occurred on the date and hour stated above.
 Immediate cause of death Cerebral thrombosis Duration 24 hrs

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>11</u>	<u>6</u>	hr. _____ min. _____

Due to Hypertension with cerebro-vascular disease
 Due to _____

9. Birthplace Iowa
(City, town, or county) (State or foreign country)
 10. Usual occupation At Home

Other conditions 131a
(Include pregnancy within 3 months of death)

11. Industry or business _____
 12. Name J. S. Smith
 13. Birthplace Don't know New York
(City, town, or county) (State or foreign country)
 14. Maiden name Sarah Slaughter
 15. Birthplace Don't know
(City, town, or county) (State or foreign country)

Major findings: _____
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant James S. Henry
 (b) Address 79th & Dundee Road
 17. (a) removal (Burial, cremation, or removal) (b) Date thereof 2/22/42
(Month) (Day) (Year)
 (c) Place: burial or cremation: Unionville, Mo

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? _____

18. (a) Signature of funeral director R. V. Lindsey & Sons
 (b) Address 3811 Broadway
 19. (a) Feb 21 1942 (Date received local registrar) (b) Maude E. Larson (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury _____
 23. Signature J. H. Hoffman (M. D. or other)
 Address Raytown, Mo Date signed 2-20-42

1159 (Licensed Embalmer's Statement on Reverse Side)

*Dr. Francis H. Johnson
August 12, 1927*

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.....

Leon D. Stewart

Licensed Embalmer No. *4177*

P. O. Address *Kansas City, 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.