

FILED DEC 14 1942

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 186

1. PLACE OF DEATH:

(a) County Saline Mo

(b) City or town Marshall Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Biggs Memorial Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days  
(Specify whether in this community all her life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline Mo

(c) City or town Marshall Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. 1st (If rural, give location)

(e) Citizen of foreign country? No or (No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Roberta Grove

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

20. DATE OF DEATH: Month Nov day 27  
year 1942 hour 8 minute 20 P.M.

21. I hereby certify that I attended the deceased from Nov 25, 1942  
to Nov 27, 1942  
that I last saw her alive on Nov 28, 1942  
and that death occurred on the date and hour stated above.

4. Single 5. Color Black 6. (a) Single widowed, Married  
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb 20 - 1898  
(Month) (Day) (Year)

Immediate cause of death Intestinal Obstruction Duration 5 days

Due to Humorous abdominal adhesions

Due to Numerous adhesions of uterus

Other conditions 12 2 2

8. AGE: Years 44 Months 9 Days 9 If less than one day \_\_\_\_\_

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

10. Usual occupation Housewife

Major findings: Intestinal obstruction, adhesions, uterine fibroids

Of autopsy ✓

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

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Robert Henry Henderson

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

14. Maiden name Elizabeth Henderson

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

16. (a) Informant Robert Henderson

(b) Address 714 West Miller, J. City, Mo

17. (a) Slater (b) Date thereof Nov 30 - 42  
(Burial, cremation, or removed) (Month) (Day) (Year)

(c) Place: burial or cremation int. burial, Slater, Mo

18. (a) Signature of funeral director Slater, Mo

(b) Address Slater, Mo

19. (a) Nov 30 42 (b) Miss T. O. Weathers  
(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 A. M. Surrency (M.D. or other) \_\_\_\_\_  
Address Slater, Mo Date signed 11/28/42

1210

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

97  
1  
2

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 12-10-42

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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.

Signature \_\_\_\_\_

Licensed Embalmer No. 3143

P. O. Address Water 7th

**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.**