

No. 2
5-4-41
5-17-39
X294

Dr A. Martue

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18432

State File No.

FILED JUN 7 1942 18

Registration District No.

Primary Registration District No. 5789

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Mississippi

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

(c) Name of hospital or institution:
Life
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Mississippi ⁶⁷

(c) City or town Rural
(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 RUSSEL HENDERSON

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased August 5th - 1938
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

4 8 9 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Ardalia Henderson

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

14. Maiden name Anna W. Epster

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

16. (a) Informant Ardalia Henderson

(b) Address W. of Island Mo.

17. (a) Rural (b) Date thereof 11-10-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cap. Spring

18. (a) Signature of general director Frank Shelby

(b) Address Post Office

19. (a) 5-31-42 (b) Fannie E. Bergman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4th day 14
year 1942 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from April 12, 1942 to 14th, 1942
that I last saw him alive on 14th, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death acute infection of Brain from Ear Duration _____
of the and meningitis

Due to _____

Due to _____

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

Major findings: 89a

Of operations _____

Of autopsy _____

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. J. Martue (M. D. or other) _____
Address East Prairie Mo. Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1291

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 643-736

Date Filed 6-3-43

JUN 22 1943

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.....

Not embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Travis Shelby*.....

..... Licensed Embalmer No. 272

..... P. O. Address East Prairie

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 218

Primary Registration District No. 5789

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Rural
(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 Life
years, months or days)

3. (a) PRINT FULL NAME Russel Henderson

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

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

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 7-15-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-31-43 (b) Jessie E. Bugman
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 1943
year _____ hour _____ minute _____ M.

21. I hereby certify that, I attended the deceased from _____
that I first saw _____ alive on _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature _____ (M, D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTAL

S-18432