

S. No. 2
M-9-4-41
5-17-42
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28678

FILED SEP 9 1943
Registration District No. 72

Primary Registration District No. 5679

Registrar's No. 12

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

1. PLACE OF DEATH:

(a) County Linn

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

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

(d) Length of stay: In hospital or institution 6 mo (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County LINN 58

(c) City or town NEW BOSTON 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME DEWEY LEE HENNINGER

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married 1 divorced Married

6. (b) Name of husband or wife Joan Henninger 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased July 6 1898
(Month) (Day) (Year)

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

45 1 10 hr. _____ min.

9. Birthplace Ill. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER

12. Name Stella Henninger

13. Birthplace Ill. 1
(City, town or county) (State or foreign country)

14. Maiden name Hellie Price

15. Birthplace Ill. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Joe E. Henning Jr

(b) Address New Boston

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof 8-16-43
(Month) (Day) (Year)

(c) Place: burial or cremation McBurg Ill

18. (a) Signature of funeral director C. A. Larson

(b) Address Bucklin Mo

19. (a) Aug. 24, 1943 (b) Markey Montgomery
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16
year 1943 hour 5 minutes 30 A.M.

21. I hereby certify that I attended the deceased from Called as Coroner 19 _____
that I last saw him _____ alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Struck by lightning causing instant death

Due to death

Due to _____

Other conditions (Include pregnancy within 3 months of death) 192

Major findings: Of operations 99

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) Accident

(b) Date of occurrence Aug 16-43 058

(c) Where did injury occur? Baker Township Linn Mo
(City or town) (County) (State)

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

While at work? yes (Specify type of place) _____ (e) Means of injury 3

23. Signature Dale Bunch Coroner
(Name of Registrar) (M.D. or other)

Address Marceline Mo Date signed 8-16-43

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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.

Signed

A. J. Killeland

Licensed Embalmer No.

4019

P. O. Address

New Cambria, MD

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.