

Registration District No. 331

Primary Registration District No. 24499

State File No. \_\_\_\_\_

Registrar's No. 69

1. PLACE OF DEATH:

(a) County Shelby  
 (b) City or town Shelbina  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Furnish Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 weeks  
(Specify whether years, months or days)  
 In this community 40 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby 109  
 (c) City or town Shelbina, Mo. 2  
(If outside city or town limits, write "RURAL") 0  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_ 1

3. (a) PRINT FULL NAME James Austin Kendrick

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, 2 divorced Widowed

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

7. Birth date of deceased May 6th 1860  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
83 2 27 hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

11. Industry or business Farming

12. Name John Kendrick

13. Birthplace Not Known  
(City, town, or county) (State or foreign country)

14. Maiden name Not Known

15. Birthplace Not Known  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Wm Koontz

(b) Address Shelbina, Mo.

17. (a) Burial (b) Date thereof 8/5/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbina Mo

18. (a) Signature of funeral director William Koontz  
 (b) Address Shelbina Mo

19. (a) Sept 3 43 (b) Nidge Good  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 4  
 year 43 hour 7:00 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on Aug 3, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of hip

Due to Fall

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 102 ✓

(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 J. D. Ferguson (Physician or other) 9/8/43  
 Address Shelbina Mo Date signed \_\_\_\_\_

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 9-43-1525

Date Filed SEP 10 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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Henry T. Savelle

Licensed Embalmer No. 38354

P. O. Address Melburn, N.J.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 44

Registration District No. 337

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Shelby  
(b) City or town Spainville  
(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 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

JAMES AUSTIN KENDRICK

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

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

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

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

8. AGE: Years 53 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year) \_\_\_\_\_  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Aug day 4 year 43 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediately cause of death \_\_\_\_\_

Duration

fracture of hip  
Due to I fell out of bed on cement floor and fractured hip  
Due to serious and prolonged condition  
Other conditions (Include pregnancy within 6 months of death) \_\_\_\_\_

Major findings: Accident - July 2 - 43  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

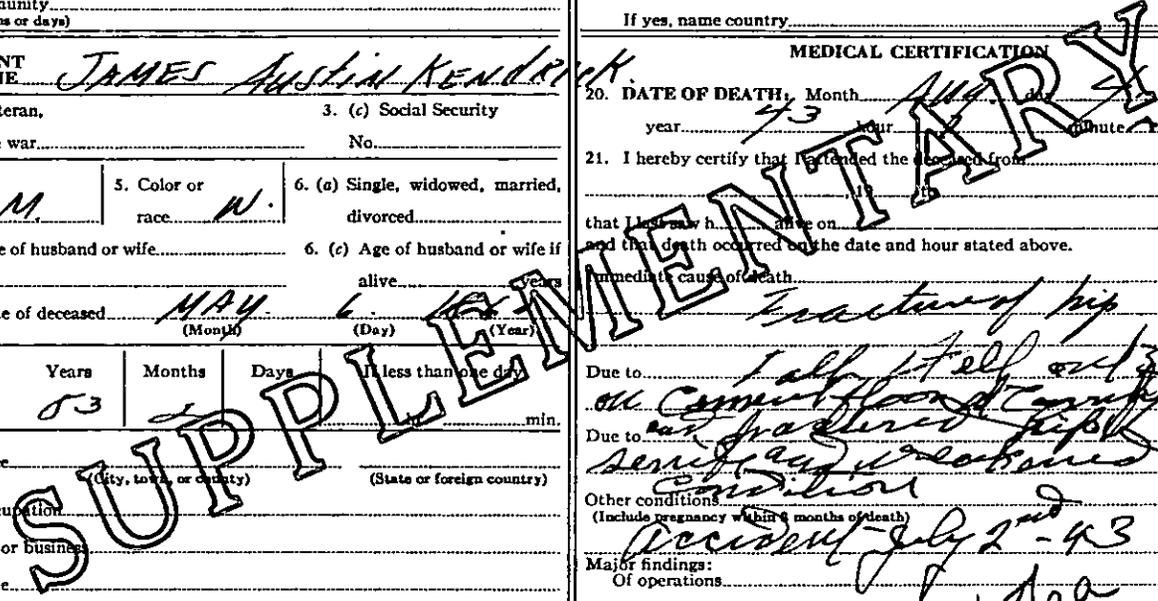
PHYSICIAN

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 fall

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_



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