

FILED JAN 15 1944  
Registration District No. 287

Primary Registration District No. 5980

Registrar's No. 11

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

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Wishart  
(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 \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk

(c) City or town Wishart  
(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 Martha Elizabeth Hensley

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 19<sup>th</sup>  
year 1943 hour 3:30 minute - A. M.

4. Sex female

5. Color or race White

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased January 1 - 1864  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov - 18 1943 to Nov - 19 1943  
that I last saw him alive on Nov - 18 1943  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>10</u>	<u>18</u>	hr. _____ min.

Immediate cause of death brain congestion

Due to accidental fall

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

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

Other conditions (Include pregnancy within 3 months of death) 180, 14

10. Usual occupation housewife

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

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name Jessie Scroggins

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

14. Maiden name Sarah Owens

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

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

(a) Accident, suicide, or homicide (specify) accident 1881

(b) Date of occurrence Nov - 18 - 43

(c) Where did injury occur? Wishart  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
home - back porch  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury fall

23. Signature H. J. [unclear] (M. D. or other)  
Address Wishart, Mo Date signed Nov 19 1943

16. (a) Informant Nora Culiss

(b) Address Bolivar, Missouri

17. (a) Burial (b) Date thereof 11-21-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eron

18. (a) Signature of funeral director Fitcherson & Co.

(b) Address Bolivar, Missouri

19. (a) Dec-14-43 (b) Hillard Dehusan  
(Date received local registrar) (Registrar's signature)

RECEIVED  
District Health Officer  
12-43-1510  
1-14-44

**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 *Carl Pitts*

Licensed Embalmer No. *3746*

P. O. Address *Bolivar, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 11

Registration District No. 287

Primary Registration District No. 5980

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**1. PLACE OF DEATH:**

(a) County Polk

(b) City or town Wishart sup  
(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)

In this community.....

**3. (a) PRINT FULL NAME** Martha E. Hensley

**3. (b) If veteran,** name war.....

**3. (c) Social Security** No.                     

**4. Sex** F

**5. Color or race** W

**6. (a) Single, widowed, married, divorced** widowed

**6. (b) Name of husband or wife**.....

**6. (c) Age of husband or wife if alive**..... year

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

**8. AGE:** Years 79 Months 1 Days 1  
If less than one day

**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**.....  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation**.....

**18. (a) Signature of funeral director**.....

**(b) Address**.....

**19. (a)**..... **(b)** Hillard E. Dickinson  
(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 Jan 20<sup>th</sup> 1943 year 19 hour 9 minute            M.

**21. I hereby certify that I attended the deceased from**..... 1943.....  
that I last saw him/her alive on..... 19.....  
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)

(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**..... (M. D. or other)  
**Address**..... **Date signed**.....

SUPPLEMENTARY

S-43424