

FILED DEC 23 1943

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

44135  
State File No.

Registration District No. 374

Primary Registration District No. 6273

Registrar's No.

1. PLACE OF DEATH:

(a) County North  
(b) City or town Rural (Fletcher)  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
In this community 5 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County North  
(c) City or town Rural (Fletcher)  
(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 BENJAMIN O. HENDRICKSON

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, married  
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive 73 years  
7. Birth date of deceased May 6 1871 (Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days 7 If less than one day hr. min.

9. Birthplace: Cole Co. (City, town, or county) Illinois (State or foreign country)

10. Usual occupation

11. Industry or business Farmer

12. Name James Hendrickson

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

14. Maiden name Mattie Farmer Zauke

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

16. (a) Informant Amanda Jean Archibald

(b) Address Grant City Mo

17. (a) Burial (b) Date thereof Nov 15 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Grant City Mo

18. (a) Signature of funeral director Brand Bros

(b) Address Denver Mo

19. (a) Nov 15 1943 (b) Arlene Scadden (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 29 year 1942 hour 11 minute 30 A. M.

21. I hereby certify that I attended the deceased from Nov 13 1943 to Nov 13 1943 that I last saw him alive on Nov 9 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial degeneration of heart  
Due to: ✓  
Due to: ✓

Other conditions: (Include pregnancy within 3 months of death) 92 h

Major findings: Of operations

Of autopsy: mo

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: S. Rose M.D. (M. D. or other)

Address: Grant City Mo Date signed: Nov 14 1943

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.....

*J.P. Brane*

Licensed Embalmer No.....

*2947*

P. O. Address.....

*Denver 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.**