

2
4-13-40
-17-39
X23159

FILED FEB 28 1944
Registration District No. 2804

Primary Registration District No. 200D

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

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Springfield Baptist Hospital
(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)

3. (a) PRINT FULL NAME ELIZA KATHERINE HENSON
3. (b) If veteran, name war None
3. (c) Social Security No. new

4. Sex Female / race W. / 5. Color or W.
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife John C. Henson
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased mar 13 - 1862
(Month) (Day) (Year)

8. AGE: Years 82 Months 10 Days 28
If less than one day _____ hr. _____ min.

9. Birthplace unk. Greenwood Georgia
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name Joe Spencer
13. Birthplace unk. unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unk. unknown
(City, town, or county) (State or foreign country)

16. (a) Informant an ill aged Henson
(b) Address Edkland - see R-2
17. (a) Burial (b) Date thereof Feb 13 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Mound
18. (a) Signature of funeral director R B Jones
(b) Address Bureau of Health
19. (a) 2-12-44 (b) or W J Standley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State mo (b) County Dallas
(c) City or town Edkland - R-2
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11 1944
year _____ hour 10 minute 30 M.
21. I hereby certify that I attended the deceased from 2-11 to 2-11 1944
and that death occurred on the date and hour stated above.
that I last saw her alive on 2-11 1944

Immediate cause of death Burns second & third degree of legs and trunk
Duration 10 hrs
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Accidental removal of clothing

PHYSICIAN

Major findings: Of operations from history stone
Of autopsy _____
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 130
(b) Date of occurrence Feb 11 1944
(c) Where did injury occur? Edkland Dallas Co Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
While at work? no (Specify type of place) Fire from
(e) Means of injury
23. Signature Robert Gorman (M. D. or other)
Address Springfield, Mo. Date signed 2/11/44

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

Chester A. Paul

Licensed Embalmer No.

3044

P. O. Address

Buffalo ms

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.