

FILED SEP 22 1944  
Registration District No. 22A

Primary Registration District No. 4279

Registrar's No. 21

1. PLACE OF DEATH:

(a) County LAWRENCE  
(b) City or town HALL TOWN  
(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 ALBERT LIFE years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County LAWRENCE  
(c) City or town HALL 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 Missouri, E. Hendrix

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, widow  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive, \_\_\_\_\_ years

7. Birth date of deceased SEPT 4 (Month) (Day) (Year) 1957

8. AGE: Years 86 Months 11 Days 16 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation HOUSE KEEPER

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

12. Name Jacob Parris

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

14. Maiden name MARY PHARIS

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

16. (a) Informant Mrs Lela McLand

(b) Address HALL TOWN MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 31 1944 (Month) (Day) (Year)

(c) Place: burial or cremation HALL TOWN CEM

18. (a) Signature of funeral director MORTIS LEIMAN

(b) Address ASH GROVE MO

19. (a) Sept 1 1944 (Date received local registrar) (b) Annex (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG day 20 year 1944 hour 2 minute \_\_\_\_\_ AM.

21. I hereby certify that I attended the deceased from Aug 20 1944 to Aug 20 1944 that I last saw h. ee alive on Aug 20 1944 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage Duration 2 hrs

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

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

Other conditions (Include pregnancy within 3 months of death) g3a1

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 S. M. Clark M.D. (M. D. or other)

Address Halltown Mo. Date signed 8-21-44

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

5500

RECEIVED

District Health Officer No. 6,

District File Number 944-1034

Date Filed SEP 20 1944

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 Maude O. Morris

Licensed Embalmer No. 2065

P. O. Address Ash Grove 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.