

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

FILED NOV 15 1944

Registration District No. **13-3**

Primary Registration District No. **5579**

Registrar's No. **23**

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Muscare

(c) Name of hospital or institution: Jasper 60 TB Hospital
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 3 weeks
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper **49**

(c) City or town Deerfield **0**
(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 _____ **0**

3. (a) PRINT FULL NAME Robert Henderson

3. (b) If veteran, name war _____

3. (c) Social Security No. 499-22-3280

4. Sex M 5. Color or race Wh 6. (a) Single, widowed, married, divorced Wid

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

7. Birth date of deceased April 3 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 6 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation Miner + Carpenter

MOTHER FATHER

11. Industry or business _____

12. Name William Henderson

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

14. Maiden name Sarah Abercrombie

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

16. (a) Informant Records

(b) Address _____

17. (a) Burial (b) Date thereof Oct 10 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funerary Home

18. (a) Signature of funeral director Walt City Hall Co

(b) Address Walt City, Mo

19. (a) Oct 9 1944 (b) Mrs. Lillie Lyle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8 year 1944 hour 8 minute 15 M.

21. I hereby certify that I attended the deceased from Sept 19 1944 to Oct 8 1944
that I last saw him alive on Oct 8 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary

Due to Silico-Tuberculosis

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) _____

(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 0

23. Signature James E. Deigler (M. D. or other) 1944
Address East City, Mo Date signed _____

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

13 b 1

1180

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

19
0
0

4-11-879

4-11-879

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 myself

Registered Apprentice No. _____

working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City, 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.