

FILED DEC 27 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 1000

Registrar's No. 871

1. PLACE OF DEATH

(a) County Greene Mo.  
(b) City or town Springfield Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Springfield Baptist Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 Days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene  
(c) City or town Springfield Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1905 W. Phelps  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

George W. Hendricks

3. (b) If veteran, name war

UNK.

3. (c) Social Security No.

UNK.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married Married

6. (b) Name of husband or wife Ada Hendricks

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased June 25, 1870  
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 7  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired Sensitive

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

12. Name George W. Hendricks

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

14. Maiden name Susan Adams

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

16. (a) Informant Ada Hendricks

(b) Address Springfield Mo. 1905 W. Phelps

17. (a) Bourbon (b) Date thereof Dec 4, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galena, Ky.

18. (a) Signature of funeral director T. B. Chappin

(b) Address Dark Mo.

19. (a) 12-4-44 (b) J. S. Maudslayi  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 2  
year 1944 hour 2 minute 40 P.M.

21. I hereby certify that I attended the deceased from Nov. 30, 1944, to Dec 2, 1944,  
that I last saw him alive on Nov. 28, 1944,  
and that death occurred on the date and hour stated above.

Immediate cause of death Senary of Stomach. was operated at Columbia Mo. 1st of Nov.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) H6

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 \_\_\_\_\_  
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) (c) Means of injury \_\_\_\_\_  
23. Signature J. S. Maudslayi (M. D. or other) \_\_\_\_\_  
Address Dark Mo. Date signed 12-4-44

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

27  
2  
6

**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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Orank 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.**