

FILED MAY 31 1945

Registration District No. **77**

Primary Registration District No. **5345**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Dade**
(b) City or town **Sac Township**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2 miles S. of Crisp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **38 years** (Specify whether years, months or days)
In this community **38 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Dade**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **2 miles S. of Crisp**
(If rural, give location)
(e) Citizen of foreign country? **-** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **HERBERT ALLEN FOX**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **October 8 1906**
(Month) (Day) (Year)

8. AGE: Years **38** Months **6** Days **22** If less than one day _____ hr. _____ min.

9. Birthplace **Dade County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER
12. Name **Henry Fox**
13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Duncan**
15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **James Fox**
(b) Address **Stockton Mo**

17. (a) **Burial** (b) Date thereof **4-30-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Bald Mound**

18. (a) Signature of funeral director **Sam C. Sencerney J.**
(b) Address **Sherrfield Mo.**

19. (a) **4-30-45** (b) **Lydia Nixon**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **28**
year **1945** hour **3** minute **15** M.

21. I hereby certify that I attended the deceased from **4-26** 19**45** to **4-28** 19**45**
that I last saw him alive on **4-28** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Pneumonia** Duration **7 days**

Due to _____
Due to _____

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

Major findings: Of operations **11/10**
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)
(1) _____ (2) Means of injury _____
23. Signature **Dr. J. P. ...** (Name and address)
Address **Stockton Mo.** Date signed **4-30-45**

1343

(Licensed Embalmer's Statement on Reverse Side)

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

1900

RECEIVED
District Health Officer, No. 6,
License No. Number *545-620*
Date filed *MAY 28 1945*

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 *Sam E. Senseney Jr.*

Licensed Embalmer No. *4099*

P. O. Address *Greenfield 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.