No. 2
—2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18108

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 970

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike

(c) City or town Bowling Green
(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 Charles Dan Hendricks

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race Colored

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased November (Month) 3 (Day) 1919 (Year)

8. AGE:

Years	Months	Days	If less than one day
25	5	16	..... hr. ..... min.

9. Birthplace Bowling Green (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Truck Driver

11. Industry or business .....

FATHER
12. Name Howard Hendricks
13. Birthplace Unknown (City, town, or county) Virginia (State or foreign country)

MOTHER
14. Maiden name Nannie McPike
15. Birthplace Bowling Green (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Nannie Hendricks
(b) Address Bowling Green, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-45 (Month) (Day) (Year)
(c) Place: burial or cremation Bowling Green, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) APR 28 1945 (Date received local registrar) (b) E. E. McLawson M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18th year 1945 hour 6.00 minute P.M.

21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...; that I last saw h... alive on ....., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Crushed chest and broken back	
Due to Accident	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accident
(b) Date of occurrence April 18, 1945.
(c) Where did injury occur? St. Louis Co., Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Road (Specify type of place)
While at work? Yes (e) Means of injury 3

23. Signature Arnold J. Willmann Coroner (M.D. or other)
Address Clayton, Mo. Date signed 4-20-45

(Licensed Embalmer's Statement on Reverse Side)

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 Albert G. Hoffe

Licensed Embalmer No. 2971

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jump

Registration District No. 317 Primary Registration District No. 8063 Registrar's No. 970

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Clayton
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or 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 Charles O. Hendricks
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race Col
6. (a) Single, widowed, married, divorced Div
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar (Month) 3 (Day) (Year)
8. AGE: Years 25 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 18 year 1945 hour 6.00 minute A.M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Crushed chest and broken back — Duration
Due to Accident
Due to
Other conditions
(Include pregnancy within 3 months of death)
Collision with stray horse
Major findings:
Of operations Truck overturning
Of autopsy

SUPPLEMENTARY INFORMATION REQUESTED

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) Accident
(b) Date of occurrence April 18 1945
(c) Where did injury occur? St. Louis County (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Road (Specify type of place)
While at work? yes (Specify yes or no) Means of injury Blunt Impact
23. Signature Arnold J. Wilmann Coroner
Address Clayton Mo Date signed 4-20-45

18108