S. No. 2
1—8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 30 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22935

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3031

1. PLACE OF DEATH:

(a) County: Jackson

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

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

(d) Length of stay: In hospital or institution 26 days (Specify whether years, months or days)

In this community UNKNOWN

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 548 Main 8
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME: Albert Hendrickson

3. (b) If veteran, name war: UNKNOWN

3. (c) Social Security No.: UNKNOWN

4. Sex: male 0

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: 1 (Month) 28 (Day) 74 (Year)

8. AGE: Years 71 Months 5 Days 2 If less than one day hr. min.

9. Birthplace: Kansas (City, town, or county) / (State or foreign country)

10. Usual occupation: UNKNOWN

11. Industry or business:

MOTHER FATHER

12. Name: Oliver Hendrickson

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

14. Maiden name: Phoebie Scranton

15. Birthplace: Illinois (City, town, or county) / (State or foreign country)

16. (a) Informant: R.R.L.

(b) Address: General Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-20-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Lee's Summit

18. (a) Signature of funeral director: Wm. A. Lohmeyer

(b) Address: City Mortician

19. (a) 7-20-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30 year 1945 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from June 5, 1945, to June 30, 1945; that I last saw him alive on June 30, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: adenocarcinoma of pancreas

Due to:

Due to:

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

Major findings: Of operations: 468

Of autopsy:

Duration

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? (Specify type of place)

While at work? (e) Means of injury: 0

23. Signature: Clark W. Sebastian (M. D. or other)

Address: Med. Dir. K.C. General Hospital Date signed

(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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed Wm A Lohmeyer

Licensed Embalmer No. 3089

P. O. Address KC 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.