S. No. 2
M—2-43
v. 5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25256

FILED JUL 18 1945

Registration District No. 249 Primary Registration District No. 4513 Registrar's No. 9

1. PLACE OF DEATH:

(a) County Sullivan

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

(c) Name of hospital or institution: 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community years, months or days) 3 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan 105

(c) City or town Green Castle (If outside city or town limits, write "RURAL") 0

(d) Street No. (If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME HENRY. WALTER

3. (b) If veteran, name was

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct. (Month) 2 (Day) 1859 (Year)

8. AGE: Years 85 Months 8 Days 11 If less than one day hr. min.

9. Birthplace Reading (City, town, or county) Ill (State or foreign country) 1

10. Usual occupation Ret Farmer

11. Industry or business

FATHER
12. Name D. K.
13. Birthplace D. K. (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name D. K.
15. Birthplace D. K. (City, town, or county) (State or foreign country) 9

16. (a) Informant Alvie Walter Sinneus, Mo

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June-16 45 (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Brookfield

18. (a) Signature of funeral director Hill Funeral Home

(b) Address Brookfield Mo.

19. (a) 6-14-1945 (Date received local registrar) (b) Mrs Laura Shaw (Registrar's signature) deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13 year 1945 hour 9 minute 45P M.

21. I hereby certify that I attended the deceased from May 17, 1945, to June 13, 1945 that I last saw him alive on June 15, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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)

(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

23. Signature [signature] (M. D. or other) 02

Address Grain City Mo Date signed 6-14-45

1351

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer, No. 10
District File Number 7-45-1164
Date Filed JUL 17 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 J. H. Blackstock

Licensed Embalmer No. 2246

P. O. Address Brookfield, Me

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.