

**FILED** JAN 14 1946

Registration District No. **128**

Primary Registration District No. **2000**

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

1. PLACE OF DEATH:

(a) County **GREENE**  
(b) City or town **Springfield**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Springfield Baptist Hospital**  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Dallas** **30**  
(c) City or town **Buffalo Rural** **0**  
(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 **HARRIETT D. HENDRICKSON**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widow, married, divorced **Widow**

6. (b) Name of husband or wife **UNK.** 6. (c) Age of husband or wife if alive **Dec** years

7. Birth date of deceased **Jan - 6 - 1863**  
(Month) (Day) (Year)

8. AGE: Years **87** Months **10** Days **29** If less than one day hr. min.

9. Birthplace **Dallas Co. Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

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

12. Name **Benjamin Powell**

13. Birthplace **Dallas Co. Mo.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Newport**

15. Birthplace **Dallas Co. Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Joe Hendrickson**  
(b) Address **Springfield Mo**

17. (a) **Burial** (b) Date thereof **12-7-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Method**

18. (a) Signature of funeral director **R. Brown**  
(b) Address **Buffalo Mo**  
19. (a) **12-5-45** (b) **R. W. Handley**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **5**  
year **1945** hour **12** minute **01 P.** M.

21. I hereby certify that I attended the deceased from **Oct 25** 19**45** to **Dec 5** 19**45**;  
that I last saw her alive on **Dec 5** 19**45**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of pancreas**

Due to **Chronic gall bladder disease**

Due to **Acute jaundice**

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

Major findings: Of operations **No operation**

Of autopsy **H69**

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)  
(e) Means of injury \_\_\_\_\_

23. Signature **Robert Lynn** (M. D. or other) **M.D.**  
Address **Springfield, Mo.** Date signed **12/7/45**

Duration

**Unknown**

**5 yrs**

**3 mo**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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 Leonard B. Jones

Licensed Embalmer No. 2508

P. O. Address Bufile 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.**

X