

No. 2  
1-2-43  
5-17-39  
X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3416**  
Registrar's No. **49**

**FILED JAN 28 1946**

Registration District No. 226 Primary Registration District No. 4337

1. PLACE OF DEATH:

(a) County Monroe  
(b) City or town Madison Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1 Madison  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether  
In this community Life time (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Monroe  
(c) City or town Madison Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 11  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Jane Henderson  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 27  
year 1945 hour 6 minute 10 A.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
Date I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
(b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive 11 years  
7. Birth date of deceased 1-1874  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 71 Months 11 Days 14 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no

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

10. Usual occupation at home

11. Industry or business at home

MOTHER FATHER { 12. Name Thomas Pullen  
13. Birthplace N.Y. (City, town, or county) (State or foreign country)  
14. Maiden name Sarah Margaret Ferguson  
15. Birthplace Mo (City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant Mrs. Capitola Eck  
(b) Address 325 Northhead Moberly Mo.

17. (a) Cremated (b) Date thereof 12-28-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Coke Grove

18. (a) Signature of funeral director W. S. Thompson  
(b) Address Madison, Mo.

19. (a) Jan 26 1946 (b) Clive Little  
(Date received local registrar) (Registrar's signature)

23. Signature Russell D. Wilson (M. D. or other) Coroner  
Address Monroe City Mo Date signed 1/28/46

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

100650

RECEIVED

District Health Officer No. 10

District File Number 1-46-191

Date Filed JAN 26 1946

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 Mrs. Ruth Thompson

Licensed Embalmer No. 3284

P. O. Address Madison, 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.