

FILED JAN 29 1946

Registration District No. _____ Primary Registration District No. 4-223 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Harrison
(b) City or town Stotestown, Harrison Co. Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stotestown Mo. Gen. Hosp. #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 20 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Harrison
(c) City or town Stotestown
(If outside city or town limits, write "RURAL")
(d) Street No. Gen. Hosp. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Richard Byron Hendrick

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race Wht 6. (a) Single, widowed, married, divorced _____

(b) Name of husband or wife Ernie Miller Hendrick 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 21 1881
(Month) (Day) (Year)

8. AGE: Years 64 Months 10 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Retired

12. Name John S. Hendrick

13. Birthplace Rome Co. Tenn. (City, town, or county) (State or foreign country)

14. Maiden name Arrietta Tipton

15. Birthplace Louisiana (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Edgar B. Hendrick

(b) Address Richards Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14-46
(Month) (Day) (Year)

(c) Place: burial or cremation Richland Bur. Richland Mo.

18. (a) Signature of funeral director O. D. Cheney
(b) Address 175 S. 1st Kansas

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17 year 1946 hour 10 minute 25 P. M.

21. I hereby certify that I attended the deceased from Nov 19, 1945 to Dec 26, 1945

that I last saw him alive on Dec 26, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 3 months

Due to Chronic nephritis with several hypertensive heart disease years

Due to _____

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

Major findings: Of operations none

Of autopsy none 1315

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 Raymond Beach (M. D. or other) M.D.

Address Fort Scott Kansas Date signed 1-15-46

FEB 1 1946

PUBLIC HEALTH DISTRICT #7
RECEIVED 95623LA, MD.
District Health Officer No. 7,
District file number 12-45-1295
Date Filed 1-28-46

17320

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. ~~7599~~
working under my personal supervision.

Signed..... *O. A. Cheney*
Licensed Embalmer No. 1599
P. O. Address..... *W. Scott Hansen*

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.

2B
-45
43680

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7 et

Registration District No. 361

Primary Registration District No. 228

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Henry, Mo. Rural
(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 _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Richard B. Headrick

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eunice Miller Headrick 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 2, 1921
(Month) (Day) (Year)

8. AGE: Years 64 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Jan 17, 1946 (b) Bertha Single
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

3450

4342