

FILED MAR 18 1946

Registration District No. 27

Primary Registration District No. 5052

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Pike  
(b) City or town Rural - Spencer  
(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 110 (Specify whether  
In this community 60 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike  
(c) City or town Rural (If outside city or town limits, write "RURAL")  
(d) Street No. Spencer Township (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME

Zella Pearl Hendrix

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color race White

6. (a) Single, widowed, married Married

6. (b) Name of husband or wife Wm H Hendrix

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Aug 2 - 1884  
(Month) (Day) (Year)

8. AGE: Years 61 Months 4 Days 29 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

12. Name Jeff Green

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

14. Maiden name Celia Cleary

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

16. (a) Informant W. H. Hendrix

(b) Address Curryville Mo

17. (a) Burial (b) Date thereof 1-3-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Curryville Mo

18. (a) Signature of funeral director W. D. Elmore

(b) Address Bonning Green

19. (a) 3-1-46 (b) Bill Robinson  
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 1  
year 1946 hour 1:30 minute P. M.

21. I hereby certify that I attended the deceased from 2-8-1945 to Dec, 1945

that I last saw her alive on 12-20, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral  
atrophy  
Due to.....

Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none  
Of autopsy none

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) no  
(b) Date of occurrence none  
(c) Where did injury occur? no  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at no (Specify type of place) (e) Means of injury no

23. Signature Bill Robinson (M. D. or other)  
Address St. Louis, Mo Date signed 1-2-46

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 3-46-526

Date Filed MAR 16 1946

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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 W. B. Emore

Licensed Embalmer No. 3466

P. O. Address Brooklyn, New York

**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.**