

**FILED JUL 29 1946**

Registration District No. **2**

Primary Registration District No. **1000**

Registrar's No. **764**

**1. PLACE OF DEATH:**

(a) County **Buchanan**  
(b) City or town **St. Joseph**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Missouri Methodist Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **17 days**  
(Specify whether  
In this community **50 years**  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Buchanan**  
(c) City or town **St. Joseph, Mo.**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **22nd & Gene Field Rd**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Edward C. Hendricks**

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

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widower**  
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive **2** years

7. Birth date of deceased **January 12 1877**  
(Month) (Day) (Year)

8. AGE: Years **69** Months **5** Days **6** If less than one day hr. min.

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

10. Usual occupation **Dairyman**

11. Industry or business **unk**

MOTHER FATHER

12. Name **unk**

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

14. Maiden name **unk**

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

16. (a) Informant **Mrs Roy Lillie**  
(b) Address **Industrial City, Mo.**

17. (a) **Burial** (b) Date thereof **6-15-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Ashland Cemetery**

18. (a) Signature of funeral director **Barry Funeral Home**  
(b) Address **St. Joseph, Mo.**

19. (a) **July 8, 1946** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **June** day **14**  
year **1946** hour **2** minute **00** A. M.  
21. I hereby certify that I attended the deceased from **May 25**  
**1946** to **June 13**, 1946  
that I last saw him alive on **June 13**, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cellulitis of Lf. Foot - Accute suppurative** Duration **10 days**  
Other Conditions: **Generalized Arteriosclerosis**  
**Chronic Myocarditis**

Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations:  
Of autopsy: **97**

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 **5**  
23. **Charles H. Keener** (M. D.)  
Address **Kirkpatrick Bldg.** Date signed **6-14-46**

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

18600

**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, \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 3986

P. O. Address St. Joseph, 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.**