

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 174

Primary Registration District No. 3035

Registrar's No. 46

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

1. PLACE OF DEATH

(a) County Lafayette

(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
125 N. 16th St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 6 months

3. (a) PRINT FULL NAME SARAH ANN HENDERSON

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female 5. Color or race wh

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Charles William Henderson 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb 22 1861
(Month) (Day) (Year)

8. AGE: Years 85 Months 4 Days 2 If less than one day hr. min.

9. Birthplace Cole County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name James Crews ?

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

14. Maiden name Mary McBurns ?

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

16. (a) Informant Mrs. Leslie Page

(b) Address 125 N 16th Lexington, Mo.

17. (a) Burial (b) Date thereof June 24, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation F.O.D.C. cemetery Otterville

18. (a) Signature of funeral director Hays Painter Mo

(b) Address otterville, mo

19. (a) 2 July 1946 (b) Registrar's signature
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan 71

(c) City or town Flarene (Rural) 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 1

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24th
year 1946 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb 15, 1945 to June 27, 1946

that I last saw her alive on June 27th, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death acute Pulmonary Effusion - with Acute Myocardial degeneration Duration 2 1/2 hrs

Due to Complications of Renal & Cardiac

Due to _____

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

Major findings: Of operations _____

Of autopsy 46

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) _____ (e) Means of injury _____

While at work? _____

23. Signature Dr. J. C. Bellum (M. D. or other) Mo

Address Dep. Engler MO Date signed 4/27/46

RECEIVED

District Health Officer No. 8, 3

District File Number _____

Date Filed 7-8-46

STATEMENT BY LICENSED EMBALMER

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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 Geo. M. K. Law
Licensed Embalmer No. 2983
P. O. Address Washington 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.