

S. No. 2
1-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Max Fitch
State File No. 8636

FILED MAR 28 1947
128

Registrar's No. 196

Registration District No. Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: St. Johns
(If not in hospital or institution, write street number or location) 10 Days

(d) Length of stay: In hospital or institution. 10 Days (Specify whether years, months or days)

In this community 25 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No. 727 Lincoln 6
(If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME William Arthur Hendricks

3. (b) If veteran, name war Yes

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5 th. year 1947 hour 4 minute 30 A. M.

21. I hereby certify that I attended the deceased from 10-1 to Mar 5-47 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Rosa Hendricks

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased November 23 1868
(Month) (Day) (Year)

Immediate cause of death Cardio-Heart-Vascular 4 mo
Disease

Duration

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>3</u>	<u>12</u>	hr. min.

Due to _____

Due to _____

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

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

Major findings: 131A

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER {

12. Name Wilburn Hendricks

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

14. Maiden name Mary Kerr

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

16. (a) Informant Mrs. Rosa Hendricks

(b) Address 727 Lincoln St. Springfield,

17. (a) Burial (b) Date thereof 3-7-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

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? 0

18. (a) Signature of funeral director W.L. Dunn

(b) Address Springfield, Mo.

19. (a) 3-7-47 (b) W. E. Standley M.D.
(Date received local registrar) (Registrar's signature)

While at work _____ (Specify type of place)

(c) Means of injury _____

23. Signature Max Fitch (M. D. or other) MD

Address Springfield Mo Date signed 3-7-47

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..... *R. S. Mc Conn*.....

Licensed Embalmer No. *2727*.....

P. O. Address *Springfield*.....

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.