No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAY 22 1948
Registration District No. 1449

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 16365
Registrar's No. 2006

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: The Child Rens Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days 9 hrs 42 min. (Specify whether
In this community 5 days 9 hr 42 Mins. 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") 6
(d) Street No. 637 N. Kansas 1
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Melvin Russell Hendrix
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 1 (Day) 1948 (Year)

8. AGE: Years | Months | Days | If less than one day
10 days hr. min.

9. Birthplace Springfield Mo. (City, town, or county) (State or foreign country)
10. Usual occupation infant
11. Industry or business

FATHER
12. Name Melvin Eugene Hendrix
13. Birthplace Springfield Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dorothy Smith
15. Birthplace Springfield Mo. (City, town, or county) (State or foreign country)

16. (a) Informant father M. E. Hendrix
(b) Address Springfield Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-10-48 (Month) (Day) (Year)
(c) Place: burial or cremation Springfield Mo
18. (a) Signature of funeral director H. Sohmeyer
(b) Address Springfield Mo
19. (a) 5-11-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10th
year 1948 hour 1 minute 57 P. M.
21. I hereby certify that I attended the deceased from ~~May 5, 1948, to May 10, 1948~~ Pathologist that I last saw ~~him~~ alive on May 10, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bilateral Confluent Bronchopneumonia	
Terminal Peritonitis	
Due to Tracheoesophageal Fistula	
Due to	
1578	
Other conditions (Include pregnancy within 3 months of death)	

~~Major findings:~~ ~~Of operations~~ Tracheoesophageal Fistula
Pble Stricture of Duodenum
Peritonitis
Of autopsy: Bronchopneumonia
Bilateral

PHYSICIAN
Underline the cause of 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

23. Signature O. C. H. Schmidt (M. D. ~~or other~~)
Address St. Lukes Hosp. Date signed 5-10-48

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.