

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27494

State File No. _____

FILED SEP 9 1949
BIRTH NO. 50629-49 REG. DIST. NO. 241 PRIMARY REG. DIST. NO. 5828 Registrar's No. 37

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

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>N. Madrid</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Le Sieur Tap</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Ruth</u>	b. (Middle) <u>Ann</u>	c. (Last) <u>Henderson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 8 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>Aug 3 1949</u>	9. AGE (In years last birthday) / UNDER 1 YEAR Months / Days / Hours / Min. <u>5</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (State or foreign country) <u>New Madrid Co MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>✓</u>	13b. MOTHER'S MAIDEN NAME <u>Isabell Henderson</u>	14. NAME OF HUSBAND OR WIFE <u>✓</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>✓</u>	16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Dan Henderson</u> ADDRESS <u>Rt#1 Portageville Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7455</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>No Medical Attendant.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Lisha Caldwell Mid-wife</u> DUE TO (c) <u>Cause of death Unknown</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>✓</u>	19b. MAJOR FINDINGS OF OPERATION <u>✓</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>✓</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>✓</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>✓</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>✓</u>
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ed Hedyguth, Coroner</u>	23b. ADDRESS <u>New Madrid, Mo.</u>	23c. DATE SIGNED <u>Aug 10 49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug 9 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Colored Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Portageville Mo</u>
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DATE REC'D BY LOCAL REG. <u>Aug 20 1949</u>	REGISTRAR'S SIGNATURE <u>Ellen DeLisle</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>DeLisle Funeral Parlor</u>	ADDRESS <u>Portageville, Mo</u>
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RECEIVED SEP 619
District Health Office No.
District File Number 949-
Date Filed _____

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 _____

not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Signed _____
Student Embalmer

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.