S. No. 300
v. 10.48

FILED MAR 29 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10194

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2524

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Barnes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): West Frankfort 8120 4
d. STREET ADDRESS (If rural, give location): 1501 E Elm

3. NAME OF DECEASED (Type or Print)
a. (First): Alma
b. (Middle):
c. (Last): Hendrickson

4. DATE OF DEATH (Month) 3 (Day) 17 (Year) 51

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M.
8. DATE OF BIRTH: 9-4-1879
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Williamson County Ill
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: John Pulley
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Roy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME: Roy Hendrickson — ADDRESS: West Frankfort Ill

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Obstruction of sigmoid colon

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mild peritonitis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? 153 X

22. *I hereby certify that I attended the deceased from* 3/14, 1951, *to* 3/17, 1951, *that I last saw the deceased alive on* 3/17, 1951, *and that death occurred at* 2:30 a *m., from the causes and on the date stated above.*

23a. SIGNATURE: F R Bradley (Degree or title) M.D.
23b. ADDRESS: Barnes Hospital
23c. DATE SIGNED: 3/17/51

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 3-17-51
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): West Frankfort Ill

DATE REC'D BY LOCAL REG.: MAR 19 1951
REGISTRAR'S SIGNATURE: J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Rowland Mortuary Service Inc — ADDRESS: 4104 Manchester

(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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed Peter Dubroulet

Signed.....
Student Embalmer

Licensed Embalmer No. 3691

P. O. Address Dublin 10 Ms

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.