

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **15195**

FILED APR 27 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **274** PRIMARY REG. DIST. NO. **3052** Registrar's No. **129**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Pettis</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Morgan</b>	
b. CITY OR TOWN <b>Sedalia</b>		c. CITY OR TOWN <b>Versailles</b>	
c. LENGTH OF STAY (in this place) <b>20 MINUTES</b>		d. STREET ADDRESS (If rural, give location) <b>205 South Maple</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bathwell Hospital</b>			

<b>3. NAME OF DECEASED</b> (Type or Print) <b>Katherine Mable Hendrickson</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>April 19 1953</b>		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>December 12, 1886</b>		<b>9. AGE</b> (In years last birthday) <b>67</b>
			Months	Days	Hours
					Mins.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Missouri</b>	
				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	

<b>13a. FATHER'S NAME</b> <b>Charles Harry Smoyer</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Anna Louise Imhoff</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Albert George Hendrickson</b>	
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>499-16-0479</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Dr. John Lamy</b>	
(If yes, give war or dates of service)				<b>ADDRESS</b> <b>Sedalia, Mo.</b>	

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)		<b>MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Acute heart failure</b>				<b>8 hours</b>	
		<b>ANTECEDENT CAUSES</b> <b>Bronchial Asthma</b>				<b>50 yrs</b>	
		DUE TO (b) _____ DUE TO (c) _____					
		<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.					

<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						<b>241X</b>	

<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (m.)		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
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**22. I hereby certify that I attended the deceased from July 19, 1938, to April 19, 1953, that I last saw the deceased alive on April 19, 1953, and that death occurred at 5:45 p.m., from the causes and on the date stated above.**

<b>23. SIGNATURE</b> <b>J. L. Washburn, M.D.</b> (Degree or title)		<b>23b. ADDRESS</b> <b>Versailles Mo.</b>		<b>23c. DATE SIGNED</b> <b>4/20/53</b>	
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24b. DATE</b> <b>April 22, 1953</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Versailles Cemetery</b>	
				<b>24d. LOCATION</b> (City, town, or county) (State) <b>Versailles Missouri</b>	

<b>DATE REC'D BY LOCAL REG.</b> <b>4/21-1953</b>		<b>REGISTRAR'S SIGNATURE</b> <b>W. B. Campbell, M.D.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John R. Scriver, Versailles, Mo.</b>	
				<b>ADDRESS</b>	

No. 300  
10.48  
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

804

2961 2 T 7MP  
JUL 17 1958

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*James R. Scriver*

Licensed Embalmer No. *4880*

P. O. Address *Versaith, MD.*

**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.