

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31128

State File No.

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 383

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Butler County</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gideon, Mo.</u> | |
| c. LENGTH OF STAY (in this place) <u>1 Week</u> | | d. STREET ADDRESS (If rural, give location) <u>0720</u> <u>1</u> | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <u>Poplar Bluff Hospital</u> | | | |

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|--|--|---|--|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Roy</u> b. (Middle) <u>Fletcher</u> c. (Last) <u>Henson</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>8 27 1953</u> | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | |
| 8. DATE OF BIRTH <u>11-19-1873</u> | | 9. AGE (In years last birthday) <u>79</u> | | 10. IF UNDER 1 YEAR Months <u>9</u> IF UNDER 1 HOUR Hours <u>1</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |

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|---|--|--|--|---|--|
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Jenny Forrester</u> | | 14. NAME OF HUSBAND OR WIFE <u>Katie Henson (Deceased)</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Lost</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Charles Henson, Gideon, Missouri</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Neurostatic Pneumonia</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute Cardiac Decompensation</u> DUE TO (c) <u>Chronic Myocarditis</u> | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |

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|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>4222</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 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) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |

22. I hereby certify that I attended the deceased from August 19, 1953, to Aug 27, 1953, that I last saw the deceased alive on Aug. 27, 1953, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

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|---|--|--|--|---|--|
| 23a. SIGNATURE (Degree or title) <u>Frank E. Dwyer M.D.</u> | | 23b. ADDRESS <u>Poplar Bluff, Missouri</u> | | 23c. DATE SIGNED <u>9-9-53</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>8-30-1953</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Stanfield Cemetery</u> | |
| | | | | 24d. LOCATION (City, town, or county) (State) <u>Near Clarkton, Mo.</u> | |

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|---|--|---|--|---|--|
| DATE REC'D BY LOCAL REG. <u>9/11/53</u> | | REGISTRAR'S SIGNATURE <u>W. H. Mitchell</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Lloyd Russell Figgott, Ark.</u> | |
|---|--|---|--|---|--|

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

RECEIVED

SEP 14 1953

BUTLER CO. HEALTH CENTER

FILE No. _____

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Lloyd Russell

Licensed Embalmer No. 509 - Ark.

P. O. Address Piggott, Ark.

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.