

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35671

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 133 PRIMARY REG. DIST. NO. 3022 Registrar's No. 107

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>	
b. CITY OR TOWN <u>Bethany</u>	c. LENGTH OF STAY (in this place) <u>6 yrs</u>	c. CITY OR TOWN <u>Bethany</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>None</u>		d. STREET ADDRESS (If rural, give location) <u>South 9th St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Hans</u> b. (Middle) <u>William</u> c. (Last) <u>Hendricksen</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>11-5-1953</u>
--	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1881</u>	9. AGE (In years last birthday) <u>72</u>	10. MONTH <u>5</u>	10. DAYS <u>4</u>	10. HOURS <u></u>	10. MIN. <u></u>
--------------------	-------------------------------	---	------------------------------	---	--------------------	-------------------	-------------------	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salaman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	11. BIRTH PLACE (City and State or Foreign Country) <u>Clay County Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
--	--	---	--

13a. FATHER'S NAME <u>James P. Hendricksen</u>	13b. MOTHER'S MAIDEN NAME <u>Henrietta Ellertsen</u>	14. NAME OF HUSBAND OR WIFE <u>Tessie</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>Do not know</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Tessie Hendricksen</u>	ADDRESS <u>Bethany Mo</u>
---	--	---	---------------------------

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>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
	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.		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	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) _____	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 Nov 5, 1953 to Nov 3, 1953, that I last saw the deceased alive on Nov 5, 1953, and that death occurred at 3:30 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Merion Leashart M.D.</u>	23b. ADDRESS <u>Bethany Mo</u>	23c. DATE SIGNED <u>11/9/53</u>
--	--------------------------------	---------------------------------

24a. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>11-7-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Henry Funeral Home</u>	24d. LOCATION (City, town, or county) (State) <u>Louis Rapids Iowa</u>
---	--------------------------	--	--

DATE REC'D BY LOCAL REG. <u>11-7-53</u>	REGISTRAR'S SIGNATURE <u>Zola Burrier</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>MR. ...</u>	ADDRESS <u>Bethany Mo</u>
---	---	---	---------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

300  
48

1  
6

11

FILED NOV 9 - 1953

JUN 17 1957

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

*M. B. Lass*

Licensed Embalmer No. 3899

P. O. Address Bethany Mo.

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.