

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

State File No. **7992**

BIRTH **FILED APR 6 1954** REG. DIST. NO. **387** PRIMARY REG. DIST. NO. **4085** Registrar's No. **11**

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY CARROLL	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HALE	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HALE	d. STREET ADDRESS (If rural, give location) 0170
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) HENRY c. (Last) HENSLEY	4. DATE OF DEATH (Month) (Day) (Year) MAR. 26 1954
5. SEX <input checked="" type="radio"/> MALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APR. 11 - 1891 9. AGE (in years last birthday) 63 if UNDER 1 YEAR: Months 11 Days 15 if UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING 10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (City and State or Foreign Country) MEADVILLE Mo. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME JOHN HENSLEY	13b. MOTHER'S MAIDEN NAME JENNIE ENGLEMAN	14. NAME OF HUSBAND OR WIFE ANNA ROOST HENSLEY
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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) YES First World War	16. SOCIAL SECURITY NO. 425-79-22	17. INFORMANT'S SIGNATURE OR NAME Mrs. John Hensley ADDRESS Hale Mo.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 months
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis 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 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 **12-24, 1953**, to **3-26, 1954**, that I last saw the deceased alive on **3-26, 1954**, and that death occurred at **8:40 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Intendant (Degree or title) D.O.	23b. ADDRESS Chillicothe Mo	23c. DATE SIGNED 3-29-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAR. 28 - 54	24c. NAME OF CEMETERY OR CREMATORY HALE CEMETERY	24d. LOCATION (City, town, or county) (State) NORTH OF HALE Mo
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DATE REC'D BY LOCAL REG Mar. 31, 1954	REGISTRAR'S SIGNATURE Mrs. Rex Henderson	49-C	25. FUNERAL DIRECTOR'S SIGNATURE Slater Funeral Home ADDRESS Hale Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

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 L. Leopard

Licensed Embalmer No. 3970

P. O. Address Mendon 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.