

FILED SEP 28 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29782**

BIRTH NO. _____ REG. DIST. NO. **32** PRIMARY REG. DIST. NO. **5109** Registrar's No. **57**

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

1. PLACE OF DEATH a. COUNTY BOLLINGER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY BOLLINGER	
b. CITY (If outside corporate limits, write RURAL and give township) NEAR PATTON-CROOKED CK. TWP		c. CITY (If outside corporate limits, write RURAL and give township) RURAL-CROOKED CK. TWP. 0090	
c. LENGTH OF STAY (In this place) LIFE		d. STREET ADDRESS (If rural, give location) NEAR PATTON 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home			

3. NAME OF DECEASED a. (First) WILLIAM (Type or Print)		b. (Middle) MILES		c. (Last) HENSON		4. DATE OF DEATH (Month) (Day) (Year) 9 14 1954	
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH JULY 6-1894	
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months 2 Days 8		IF UNDER 1 YEAR Hours Min. 		11. BIRTHPLACE (City and State or Foreign Country) 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Public Labor				10b. KIND OF BUSINESS OR INDUSTRY None		12. CITIZEN OF WHAT COUNTRY? U.S.A	

13a. FATHER'S NAME Johr Wm. Henson		13b. MOTHER'S MAIDEN NAME MARY I. ROBINSON		14. NAME OF HUSBAND OR WIFE MINNIE KLABUNDE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW1-7-1918-7-1919491-18-5528		17. INFORMANT'S SIGNATURE OR NAME John Henson - Cassville Mo	
				ADDRESS Cassville Mo	

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) Coronary Thrombosis		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) Hypertension			
		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 4201		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on **Sept 14, 1954**, and that death occurred at **3:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Ene Ward Cassville Mo		23b. ADDRESS Cassville Mo		23c. DATE SIGNED 9-16-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-16-1954		24c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		24d. LOCATION (City, town, or county) (State) NEAR-MARQUAND MO	
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DATE REC'D BY LOCAL REG. Sept 17-54		REGISTRAR'S SIGNATURE Willie VanLomburg		25. FUNERAL DIRECTOR'S SIGNATURE Ene Ward		ADDRESS Cassville Mo	
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SEP 22 1950

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 *C. J. Loberg*
Licensed Embalmer No. 3810
P. O. Address Cape Fear, N.C.

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.