

FILED JAN 24 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3640**

BIRTH NO. _____ REG. DIST. NO. **381** PRIMARY REG. DIST. NO. **6179** Registrar's No. **3**

1050

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

1. PLACE OF DEATH a. COUNTY Sullivan			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY Sullivan		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pollock-R Jackson Twp		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pollock-Rural 1050		d. STREET ADDRESS (If rural, give location) Jackson Twp. 0
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS		
3. NAME OF DECEASED a. (First) Thomas b. (Middle) Henderson c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 1-14-1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-4-1888	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months 4 Days 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and State or Foreign Country) Sullivan MO 0		12. CITIZEN OF WHAT COUNTRY? US
13a. FATHER'S NAME Joseph Henderson		13b. MOTHER'S MAIDEN NAME Lydia Pierce		14. NAME OF HUSBAND OR WIFE Mary Ellen Staples	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME Mrs. Andrew Coffman		ADDRESS Milan
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, ashenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac - Renal Complications		
			INTERVAL BETWEEN ONSET AND DEATH 3 mo.		
			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 4/2X			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 Jan. 3, 1955 , to Jan. 14, 1955 , that I last saw the deceased alive on Jan. 13, 1955 , and that death occurred at 4:30 a. m. , from the causes and on the date stated above.					
23a. SIGNATURE Dr. Simpson (Degree or title) D. O.			23b. ADDRESS Milan, Mo.		23c. DATE SIGNED Jan. 15
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/16/55	24c. NAME OF CEMETERY OR CREMATORY Thomas Union		24d. LOCATION (City, town, or county) (State) Sullivan Co. MO	
DATE REC'D BY LOCAL REG. 1-18-1955		REGISTRAR'S SIGNATURE Mrs. H. B. Harris 320-0		25. FUNERAL DIRECTOR'S SIGNATURE Scythos ADDRESS Milan-100	

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 Wright Schoerer

Licensed Embalmer No. 2667

P. O. Address Millan, 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.