

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-021135

STATE FILE NUMBER

FILED JUN 19 1958 Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 136

1. PLACE OF DEATH a. COUNTY <u>Callaway County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Ashland ? Missouri</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp No 1</u>		Length of stay in lb <u>6 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>R.F.D.</u>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>—</u> Last <u>Hendricks</u>			4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1958</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1868</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
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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>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Ashland, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John Hendricks</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Herron</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>???????</u>	17. INFORMANT <u>Hospital Chart</u>	Address <u>Fulton, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4500</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) <u>Chon. Brain Syndrome, arteriosclerosis</u>	
	DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)
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20c. TIME OF INJURY Hour <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>—</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from June 7 to June 7, 1958 and last saw her alive on June 7 - 1958
Death occurred at 6:20 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Frank Mickiewicz, M.D.</u>	(Degree or title)	22b. ADDRESS <u>State Hosp. #1, Fulton Mo</u>	22c. DATE SIGNED <u>6-7-58</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 9-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u>
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24. FUNERAL DIRECTOR <u>Memorial Funeral Home</u>	ADDRESS <u>Columbia Mo</u>	25. DATE RECD. BY LOCAL REG. <u>June 9-1958</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>
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(Licensed Embalmer, Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *Lyman W. Spence*


Licensed Embalmer No. 

P. O. Address *Calhoun, Ga.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.