

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036219
STATE FILE NUMBER

FILED OCT 23 1958 Registration District No. 141 Primary Registration District No. 5550 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>Bowell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Bowell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hocomo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Hocomo</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		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>046</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Webster</u> Last <u>Henrich</u>			4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>58</u>		
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5. SEX <u>Males</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-1901</u>	9. AGE (In years last birthday) <u>56</u>	FUNDER 1 YEAR Months <u>11</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>4</u> Min.
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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 <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>Bowell County Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Jacob Heinrich</u>	13b. MOTHER'S MAIDEN NAME <u>Amanda Fuchs</u>	13c. NAME OF HUSBAND OR WIFE <u>Myrtle Dean Henrich</u>
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14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Myrtle Henrich</u> Address <u>Hocomo 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>Cerebrovascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral hemorrhage</u>	<u>10 min</u>
	DUE TO (c) <u>Hypertensive cardiovascular</u>	<u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443X</u>		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 _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. 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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21. I attended the deceased from <u>3/4/58</u> to <u>death</u> and last saw ^{her} him alive on <u>5/10/58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>M. L. Fowler</u> (Degree or title)	22b. ADDRESS <u>West Plain Mo</u>	22c. DATE SIGNED <u>10/20/58</u>
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23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE <u>9-21-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Amg</u>	23d. LOCATION (City, town, or county) (State) <u>Hocomo Mo.</u>
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24. FUNERAL DIRECTOR <u>Robertson's</u> ADDRESS <u>West Plain Mo</u>	25. DATE RECD. BY LOCAL REG. <u>10-21-58</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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All diseases in Part I must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

035 100

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
Signature of Student Embalmer

Signed *D. Robertson*

Licensed Embalmer No. *3432*

P. O. Address *West Plains, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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