

FILED VS OCT 19 1959

Registration District No. 5 Primary Registration District No. 3011 Registrar's No. 72 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton</u>		Length of stay in 1b <u>3 weeks</u>		c. CITY OR TOWN <u>Bogard</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Atwood Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Janie</u> Middle <u>Lorana</u> Last <u>Henderson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1959</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>July 27, 1891</u>		9. AGE (last birthday) <u>68</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book keeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>		11. BIRTHPLACE (City and state or country) <u>Bogard, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>				
13a. FATHER'S NAME <u>William Henderson</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Baird</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>					
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>195-07-2608</u>		17. INFORMANT <u>Mrs. Irene Bowles, Carrollton, Mo.</u>			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Bilateral</u>								<u>12 days</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								DUE TO (b) <u>Cerebral Embolism</u>		<u>6 Days</u>	
								DUE TO (c) <u>Myocardial Failure</u>		<u>6 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
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.)							
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		Month, Day, Year									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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			
21. I attended the deceased from <u>9-27-59</u> to <u>10-12-59</u> and last saw her <u>alive</u> on <u>10-11-59</u> Death occurred at <u>5 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Name or title) <u>John H. Platz, M.D.</u>					22b. ADDRESS <u>Carrollton, Missouri</u>			22c. DATE SIGNED <u>10-12-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct 14, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Coloma Cemetery</u>			23d. LOCATION (City, town, or county) <u>Carroll County, Mo.</u>				
24. FUNERAL DIRECTOR <u>Dickerson Funeral Home, Bogard, Mo.</u>					25. DATE RECD. BY LOCAL REG. <u>10-12-59</u>		26. REGISTRAR'S SIGNATURE <u>Am Herbert Calvert</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Samuel M. Tree, Student Embalmer No. 577

working under my personal supervision.

Student

Samuel M. Tree

Signature of Student Embalmer

Signed

R. M. Marshall, Jr.

Licensed Embalmer No.

4469

P. O. Address

Concord, N. H.

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.