

JURISDICTION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039658

FILED VS NOV 23 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1235 STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in lb <u>16 yrs.</u>		c. CITY OR TOWN <u>Springfield</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>Handley Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1507 S. Grant</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harrison</u> Middle <u>Porter</u> Last <u>Henderson</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-1-1870</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mail route</u>		11. BIRTHPLACE (City and state or country) <u>Grove Spring- Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samuel Henderson</u>			13b. MOTHER'S MAIDEN NAME <u>Jalitha Dugger</u>		14. NAME OF HUSBAND OR WIFE -----		
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>None</u>		17. INFORMANT <u>Otha Henderson-Springfield, Mo.</u> Address _____			
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>Cerebral apoplexy</u>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
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 type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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>11/12/59</u> to <u>11/16/59</u> and last saw him alive on <u>11/16/59</u> Death occurred at <u>8:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Loman D. Brown M.D.</u>				22b. ADDRESS <u>31 1/2 College</u>		22c. DATE SIGNED <u>11/19/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-20-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shaddy Cemetery</u>		23d. LOCATION (city, town, or county) (State) <u>Wright County, Missouri</u>			
24. FUNERAL DIRECTOR <u>Rex Rainey Springfield, Mo.</u> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <u>11-20-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie S. Dreeton</u>	

DOCUMENT

MEDICAL CERTIFICATION

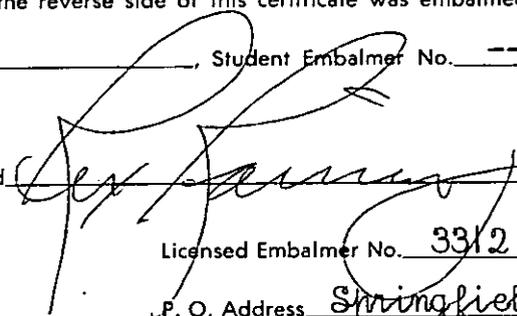
BY AFFIDAVIT OF

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 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 
Licensed Embalmer No. 3312
P. O. Address Springfield,

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.