

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000318

FILED VS FEB 6 1961

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STATE FILE NUMBER

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AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Daviess</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>32 days</i>	c. CITY OR TOWN <i>Gallatin</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Methodist Hospital</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First <i>Frank</i> Middle <i>Austin</i> Last <i>Henry</i>			4. DATE OF DEATH Month <i>January</i> Day <i>31</i> Year <i>1961</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14 1875</i>	9. AGE (last birthday) <i>85</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>
IF UNDER 24 HR Hours <i>0</i> Min. <i>0</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Minister</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Church</i>	11. BIRTHPLACE (City and state or country) <i>USA</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13a. FATHER'S NAME <i>John Wilson Henry</i>			13b. MOTHER'S MAIDEN NAME <i>Mary Jane Walker</i>		14. NAME OF HUSBAND OR WIFE <i>Jenny Henry</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <i>No</i> or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Mrs. Paul Frazier, Gallatin, Mo.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
DUE TO (b) <i>Atherosclerotic heart disease</i>					<i>5 years</i>
DUE TO (c) _____					_____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Uremia and prostatic hypertrophy</i>					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 <i>12/29/60</i> to <i>1/31/61</i> and last saw her/him alive on <i>1/31/61</i> Death occurred at <i>1/31/61</i> <i>6:30 P.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>H. F. Ware MD</i>			22b. ADDRESS <i>St Joseph, Mo.</i>		22c. DATE SIGNED <i>2/1/61</i>
23a. BURIAL, CREMATION, REBURY (Specify) <i>Burial</i>	23b. DATE <i>Feb. 2, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Brown Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Gallatin, Mo.</i>		
24. FUNERAL DIRECTOR ADDRESS <i>Clark Funeral Home St. Joseph, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>Feb. 3, 1961</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>		

(Licensed Embalmer's Statement on Reverse Side)

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TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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DOCUMENT

BY AFFIDAVIT OF *H.L. Warren, M.D.*

MEDICAL CERTIFICATION

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 *Earl A. Clark*

Licensed Embalmer No. 4238

P. O. Address *St. Joseph 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.