

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004789

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 20

AMENDED

FILED VS MAR 6 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Carroll</u>		e. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton</u>		c. CITY OR TOWN <u>Bogard</u>	
Length of stay in 1b		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>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First <u>Martha</u> Middle <u>Ann</u> Last <u>Henderson</u>			Month <u>February</u> Day <u>27</u> Year <u>1961</u>
5. SEX <u>Female</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>2-25-1867</u>
9. AGE (last birthday) <u>94</u>		IF UNDER 1 YEAR	IF UNDER 24 HR
		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Mandeville, Mo.</u>
			12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Dr. W.O. Baird</u>		13b. MOTHER'S MAIDEN NAME <u>Jane L. Erickson</u>	14. NAME OF HUSBAND OR WIFE <u>William Henderson</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>none</u>	17. INFORMANT Address <u>Mrs. Irene Bowles, Carrollton, Mo</u>
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>Cerebral Thrombosis</u>			<u>2 Months</u>
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) <u>Generalized & Cerebral Arteriosclerosis</u>			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 _____ 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>Jan. 1961</u> to <u>February 27, 1961</u> last saw her <u>alive</u> on <u>Feb. 27, 1961</u>			
Death occurred at <u>5:15 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree of title) <u>John H. Platz, M.D.</u>		22b. ADDRESS <u>Carrollton, Missouri</u>	22c. DATE SIGNED <u>5-1-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bubial</u>	23b. DATE <u>Jan, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Coloma</u>	23d. LOCATION (City, town, or county) (State) <u>Carroll, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Dickerson Funeral Home Bogard Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-1-61</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Herbert Calvert</u>	

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

Sam Miller

Licensed Embalmer No.

5087

P. O. Address

Boyard, 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.