

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-61-005856**

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 5693 Registrar's No. 32

AMENDED

FILED VS. PER. 4 1961 PLACE OF DEATH a. COUNTY <b>LIVINGSTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>LIVINGSTON</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>DAWN</b>		Length of stay in 1b <b>5 YRS.</b>	c. CITY OR TOWN <b>DAWN</b>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION		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 <b>EMMA</b> Middle <b>MAY</b> Last <b>HENDRICKSON</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/6/1880</b>
9. AGE (last birthday) <b>80</b>	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) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (City and state or country) <b>CARROLL CO., MO.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>C.C. CASE</b>	
13b. MOTHER'S MAIDEN NAME <b>LYDIA CLEVINGER</b>		14. NAME OF HUSBAND OR WIFE <b>MARTIN HENDRICKSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>HAROLD HENDRICKSON: DAWN, MISSOURI</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Terminal.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Nephritis Chronic Arteriosclerosis</b> DUE TO (c) <b>3 mos</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>
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 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>Jan. 5-61</u> to <u>Feb. 6-61</u> and last saw her alive on <u>Feb 6-61</u> Death occurred at <u>10:00</u> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Joseph G. Conrad M.D.</b>		22b. ADDRESS <b>Chillicothe, Mo</b>	22c. DATE SIGNED <b>Feb. 16-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>2/9/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BLUE MOUND CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>BLUE MOUND, MISSOURI</b>
24. FUNERAL DIRECTOR ADDRESS <b>NORMAN FUNERAL HOME: Chillicothe, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Feb 23, 1961</b>	26. REGISTRAR'S SIGNATURE <b>Annaliese Taylor</b>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

MAR 9 1961

MS FEB 24 1961

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 John P. Rodgers

Licensed Embalmer No. 4963

P. O. Address Chillicothe, Miss

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.