

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-024309
STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 193

FILED AUG 14 1961

AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Moniteau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton, Missouri</u>		Length of stay in lb <u>4 months</u>	c. CITY OR TOWN <u>Clarksburg</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1,</u>		Inside Limits Yes <input 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>Asa</u> Middle <u>Kendrick</u> Last <u>Kendrick</u>			4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1961</u>		
--	--	--	--	--	--

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/13/1881</u>	9. AGE (last birthday) <u>79</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>Retired farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	--	---	---

13a. FATHER'S NAME <u>Obediah Kendrick</u>	13b. MOTHER'S MAIDEN NAME <u>Lucinda Phelan</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Dora Kendrick</u>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>	16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT Address <u>State Hospital Records Fulton, 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>Lung, left - hypostatic pneumonia</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>lungs - senile emphysema</u>		
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>chronic brain syndrome</u>	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 checked="" 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 <u>State Hosp. No. 1</u>	COUNTY <u>Callaway</u>	STATE <u>Missouri</u>
--	--	--	---------------------------	--------------------------

21. I attended the deceased from <u>April 5, 1961</u> to <u>8-10-61</u> and last saw him alive on <u>8-10-61</u> Death occurred at <u>1:45 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>Fred P. Henderson MD</u>	22b. ADDRESS <u>State Hospital No. 1</u>	22c. DATE SIGNED <u>10 Aug</u>
---	---	-----------------------------------

23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	23b. DATE <u>8/13/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg</u>	23d. LOCATION (City, town, or county) (State) <u>Clarksburg, Mo.</u>
--	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>Maupin Funeral Home, Fulton</u>	ADDRESS <u>Fulton</u>	25. DATE RECD. BY LOCAL REG. <u>Aug. 11 - 1961</u>	26. REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>
--	--------------------------	---	--

AUG 17 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 Gene C. Murphy

Licensed Embalmer No. 5092

P. O. Address Fulton, 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.