

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-010511

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2800 Registrar's No. 445C

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 2 1962

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> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b <u>14 hrs</u>	c. CITY OR TOWN <u>FORDLAND</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>ST JOHNS HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>HENNIGH</u> Last			4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1962</u>			
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5. SEX <u>FEMALE</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>7-27-1889</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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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>WEBSTER CO MO</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>TERRILL</u>	13b. MOTHER'S MAIDEN NAME <u>SARTIN</u>	14. NAME OF HUSBAND OR WIFE <u>WALTON HENNIGH</u>
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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.	17. INFORMANT <u>WALTON HENNIGH FORDLAND, MO</u>
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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 Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</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)	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
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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.)
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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
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21. I attended the deceased from <u>1948</u> to <u>1962</u> and last saw her alive on <u>March 17, 1962</u> Death occurred at <u>6:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Gene W. Farthing, M.D.</u>	22b. ADDRESS <u>1636 So. Glenstone Spgt. Mo.</u>	22c. DATE SIGNED <u>3-23-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-20-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FORDLAND CEMETERY</u>	23d. LOCATION (City, town, or county) <u>FORDLAND MISSOURI</u>
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24. FUNERAL DIRECTOR <u>Kelley-Ferrell FORDLAND, MISSOURI</u>	25. DATE RECD. BY LOCAL REG. <u>3-26-62</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Meelan</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300
Rev. 4/59
10397
21120
3
4 1
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7 0
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9 331X
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12 4-0
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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

Permit renewed 3-17-62 (Home)

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 Wm K. Terrell

Licensed Embalmer No. 4910

P. O. Address Rogersville, 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.