

S. No. 2
DM-2-43
v. 5-17-39
X35997

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 24 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33355**
Registrar's No. **198**

Registration District No. **137** Primary Registration District No. **4217**

1. PLACE OF DEATH:
(a) County **Henry**
(b) City or town **Urish mo**
(c) Name of hospital or institution:
at home in urish /
(d) Length of stay: In hospital or institution **50 years**
In this community **50 years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Henry**
(c) City or town **Urish**
(d) Street No. **at Home in Urish**
(e) Citizen of foreign country? **no**

3. (a) PRINT FULL NAME **Charles Hesson**
3. (b) If veteran, name war **50 yrs**
3. (c) Social Security No. **none**
4. Sex **m.** 5. Color or race **w**
6. (a) Single, widowed, married, divorced **S D**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive, years
7. Birth date of deceased **5 12 1873**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct** day **16**
year **1946** hour **10** minute **30 A.M.**
21. I hereby certify that I attended the deceased from **for about 2 years 1944 to 1946**
that I last saw him alive **about 6 mos ago**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Adipose Disease**
Duration **4 yrs**

8. AGE: Years **73** Months **5** Days **4**
If less than one day **yr. min.**

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: **USA**
Of autopsy

9. Birthplace **Lawrence Co Ohio**
10. Usual occupation **Farmer**

PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business
12. Name **William Hesson**
13. Birthplace **Lawrence Co Ohio**
14. Maiden name **Sarah Caldwell**
15. Birthplace **unknown U.S.A**

16. (a) Informant **Joe Hesson**
(b) Address **Urish Mo**
17. (a) **burial** (b) Date thereof **10-18-1946**
(c) Place: burial **Whiteoak Cemetery**
18. (a) Signature of funeral director **W.S. Burren**
(b) Address **Urish mo**
19. (a) **10-18-46** (b) **H.R. Henney**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place)
(e) Means of injury
23. Signature **J.E. McDonald**
Address **Oct 17-46 - Urish mo.**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1200

RECEIVED
District Health Officer No. 7
District File Number 8 K 6 10 11
Date Filed 10-23-11

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed R R Kenney

Licensed Embalmer No. 3999

P. O. Address. Clinton 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 this body is not embalmed, fact should be so stated above.