

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1959 137

59-039800

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. Registrar's No. 279

ENDED

1. PLACE OF DEATH a. COUNTY <b>Henry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Henry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Windsor</b>		Length of stay in 1b <b>5 weeks</b>	c. CITY OR TOWN <b>Calhoun</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Windsor Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>RR</b>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>Belle</b> Last <b>Henry</b>			4. DATE OF DEATH Month <b>Nov</b> Day <b>9</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1876</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Calhoun, Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>Newton Onwiler</b>		13b. MOTHER'S MAIDEN NAME <b>Lou Watkins</b>	14. NAME OF HUSBAND OR WIFE <b>William M Henry</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Ollie Green</b> Address <b>Calhoun, Mo</b>		

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) <b>Circulatory Collapse</b>			<b>30 min</b>
DUE TO (b) <b>Coronary Occlusion</b>			<b>30 min</b>
DUE TO (c) <b>Arteriosclerosis</b>			<b>30 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>Dysenteria coli</b>			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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>Calhoun</b>	COUNTY <b>Henry</b>	STATE <b>Missouri</b>
21. I attended the deceased from <b>Dec. 1956</b> to <b>Nov 9, 1959</b> and last saw her alive on <b>Nov 9, 1959</b> Death occurred at <b>11:20 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>William J. Smith</i> (Degree or title)	22b. ADDRESS <b>Windsor, Mo.</b>	22c. DATE SIGNED <b>11/10/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov 12, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calhoun cemetery</b>
23d. LOCATION (City, town, or county) <b>Calhoun, Mo</b>		(State)

24. FUNERAL DIRECTOR <b>Housey Funeral Home Calhoun, Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Nov. 12 - 1959</b>	26. REGISTRAR'S SIGNATURE <i>Mildred Bigum</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Robert L. Dunne

Licensed Embalmer No. 4510

P. O. Address Clinton

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.