

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Ste. Genevieve
Township Saline
City _____

Registration District No. 783
Primary Registration District No. 6029

File No. 28198
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Edna Hendershach

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. 11 How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 3 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Coffman
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Emerson Hendershach

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Crystal City
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Anna Belle Lyons

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Coffman
(STATE OR COUNTRY) Missouri

14. INFORMANT Minnie Lyons
(Address) Coffman Missouri

15. FILED Sept 15 1927 C. A. Boyd REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 14 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 6 P. M.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberc Pneumonia
(Necrotic form)

CONTRIBUTORY (SECONDARY) 1010
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Leo C. Basha M.D. Coroner
915, 1927 (Address) Ste. Genevieve Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

Coffman Mo Sept 15 1927

20. UNDERTAKER John Basha Ste. Genevieve Mo
ADDRESS _____

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

