

FILED JUL 10 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20789

Registration District No. 141

Primary Registration District No. 5551

Registrar's No. 81

1. PLACE OF DEATH:

(a) County Newton
(b) City or town West Plains RFD
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 65 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Henry Thos. Henry

3. (b) If veteran, name war _____ 3. (c) Social Security No.

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced M

(b) Name of husband or wife Cara May Henry 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 5/29-1881 (Month) (Day) (Year)

8. AGE: Years 65 Months 11 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace Newton Co., MO (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Geo. Henry

13. Birthplace unk (City, town, or county) (State or foreign country)

14. Maiden name Martha Burroughs

15. Birthplace unk - 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. N. S. Henry

(b) Address West Plains, MO

17. (a) B. (b) Date thereof 5/28-47 (Month) (Day) (Year)

(c) Place: burial or cremation Bennett Chapel

18. (a) Signature of funeral director Robertson

(b) Address West Plains, MO

19. (a) June 30-1947 (Date received local registrar) (b) Beatrice Cook (Registrar's signature) 297

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Newton
(c) City or town West Plains
(d) Street No. R. 7. D. # 3 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 25 year 1947 hour 12 minute 25 AM

21. I hereby certify that I attended the deceased from 4-25, 1947, to 5-25, 1947, that I last saw him alive on 5-12, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Abscess Duration 2 mo

Due to ?

Due to _____

Other conditions (Include pregnancy within 3 months of death) 80 A

Major findings: Of operations none

Of autopsy none

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? _____ (City or town) (County) (State)

(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 0

23. Signature W. P. Hamburg (M.D. or other) MD

Address West Plains, MO Date signed 6/3/47

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

16
00

RECEIVED

Sanitary Health Officer No. 5,

Sanitary No. 747267

Date Filed 7-8-47

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 _____

Geo R. Drago

Registered Apprentice No. 431

working under my personal supervision.

Signed Reginald Roberts

Licensed Embalmer No. 3435

P. O. Address Metairie, 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.