

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4109

U. O. Henriksen on  
FILED FEB 21 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 57

1. PLACE OF DEATH  
a. COUNTY Butler  
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff, Mo.  
c. LENGTH OF STAY (In this place)  
d. FULL NAME OF HOSPITAL OR INSTITUTION Poplar Bluff Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Mo. COUNTY Butler  
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN PEISKY, MO. 11211  
d. STREET ADDRESS (If rural, give location) Box 644

3. NAME OF DECEASED  
a. (First) Martha b. (Middle) Iona c. (Last) Ellsworth  
4. DATE OF DEATH (Month) (Day) (Year) Jan. 2, 1952

5. SEX Female / 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married / 8. DATE OF BIRTH June 11, 1908 9. AGE (In years last birthday) 43 IF UNDER 1 YEAR Months 5 Days 21 IF UNDER 4 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Clarkton, Ill. / 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME H. Boon 13b. MOTHER'S MAIDEN NAME, Nancy Teal 14. NAME OF HUSBAND OR WIFE Wm. David Ellsworth

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'S SIGNATURE OR NAME ADDRESS Wm. David Ellsworth Fisk, Mo.

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)  
\*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) *Ess. Thrombotic Bronchitis*  
ANTECEDENT CAUSES  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) *Over dosage adrenal*  
DUE TO (c)  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1952, to Jan 2, 1952, that I last saw the deceased alive on Jan 1, 1952, and that death occurred at 5:40 p. m., from the causes and on the date stated above.

23a. SIGNATURE *U. O. Henriksen* (Degree or title) M.D. 23b. ADDRESS Poplar Bluff Mo. 23c. DATE SIGNED 2/9/52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial / 24b. DATE Jan. 5, 1952 24c. NAME OF CEMETERY OR CREMATORY Stanfill Cem. 24d. LOCATION (City, town, or county) (State) Clarkton, Mo.

DATE REC'D BY LOCAL REG. Feb. 11-1952 REGISTRAR'S SIGNATURE *Wm. H. Johnson* 428 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. W. ANDRESS JUN. HOME CAMPBELL, MO. O.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
FEB 19 1952

BUTLER CO. HEALTH CENTER

FILE No. 252-92

252-92

OCT 11 1961

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.....

.....  
working under my personal supervision.

Student Embalmer No. ....

Signed Carol W. Green

Signed.....  
Student Embalmer

Licensed Embalmer No. 2964

P. O. Address Douglas, Pa.

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.