

FILED MAY 1 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12830

State File No.

BIRTH NO. _____ REG. DIST. NO. 101 PRIMARY REG. DIST. NO. 5410 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY DOUGLAS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY DOUGLAS	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN BLANCHE R RICHLAND		c. CITY OR TOWN BLANCHE	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) 0340	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) HENRY b. (Middle) c. (Last) TETRICK			4. DATE OF DEATH (Month) (Day) (Year) APRIL 10 1956		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 9 1872	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	11. BIRTHPLACE (City and State or Foreign Country) BLANCHE MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME JAMES TETRICK		13b. MOTHER'S MAIDEN NAME LUDE BELL		14. NAME OF HUSBAND OR WIFE LILLIE TETRICK	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME LILLIE TETRICK ADDRESS BLANCHE MO.	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ * ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) did not have a doctor 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
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 7955
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **9:50A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wesley Bushman L.P.	23b. ADDRESS Ava Mo	23c. DATE SIGNED Apr 16-56
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4 11 1956	24c. NAME OF CEMETERY OR CREMATORY EATON
24d. LOCATION (City, town, or county) (State) BLANCHE MO.		

DATE REC'D BY LOCAL REG. Apr 16-56	REGISTRAR'S SIGNATURE Wesley Bushman	25. FUNERAL DIRECTOR'S SIGNATURE GLINKINGBEARD ADDRESS FUNERAL HOME AVA MO
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4-0

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.....

Licensed Embalmer No.....

P. O. Address

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.