No. 2
5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23287

Registration District No. 11 — Primary Registration District No. 5038 — Registrar's No. 65

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Rural (Ash twp) (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6 mi SW of Washburn (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---- In this community Most of Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barry

(c) City or town Rural (Ash Twp) (If outside city or town limits, write "RURAL")

(d) Street No. 6 mi SW of Washburn (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country ----

3. (a) PRINT FULL NAME John Price HENRY

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

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

6. (b) Name of husband or wife Sarah Ann Henry

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased March (Month) 17, (Day) 1860 (Year)

8. AGE: Years 87 | Months 2 | Days 29 | If less than one day -- hr. --- min.

9. Birthplace Barry Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER

12. Name La Fayett Henry

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

14. Maiden name Sarah Jane Cunningham

15. Birthplace Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant Sarah Ann Henry

(b) Address RFD; Washburn, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/1947 (Month) (Day) (Year)

(c) Place: burial or cremation Roller Cemetery

18. (a) Signature of funeral director Koon Funeral Home

(b) Address Cassville, Missouri

19. (a) June 27-47 (Date received local registrar) (b) Grace Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16th. year 1947 hour 1:00 minute A. M.

21. I hereby certify that I attended the deceased from March 1946 to Mar- June 16 1947 that I last saw him alive on June 10 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Toxemia.	
Due to Chronic Nephritis.	
Due to	
Other conditions (Include pregnancy within 3 months of death) Fracture of hip due to a fall.	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN: Underline cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Dr. C. R. Brown (M. D. or Coroner)

Address Seligman Mo. Date signed 6/18/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 147-706
Date Filed JUN 21 1947

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed W C Roan

Licensed Embalmer No. 4359

P. O. Address Cassville, 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.

No. 2B
M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec 9

Registration District No. 11 Primary Registration District No. 5038 Registrar's No. 65-9

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

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(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 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John P. Henry
3. (b) If veteran, name war
3. (c) Social Security No.

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

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years

7. Birth date of deceased March 17 1866
(Month) (Day) (Year)

8. AGE: Years 81 | Months 2 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 16 year 1946 hour p.m. minute M.

21. I hereby certify that I attended the deceased from Dec 15-46 to 19..; that I last saw h.. alive on June 15 1947 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
(a) Bronchopneumonia
Due to (Lingering sickness)
Due to Chronic Nephritis
Other conditions (Include pregnancy within 3 months of death) Fractured hip

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident Fall
(b) Date of occurrence Dec 15 1946 1:45
(c) Where did injury occur? on house (City or town) Country (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? fall on floor, of Country home
(Specify type of place)
While at work? (e) Means of injury

23. Signature C. T. Brown (M. D. or Coroner) MD
Address Seligman Mo Date signed 3/4/47

23287