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Rev. 5-17-3[illegible]
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 14 1944
Registration District No. 3[illegible]6

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11947

Primary Registration District No. 3060

Registrar's No. 6

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Farmington City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 417 Warren
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois
(c) City or town Farmington
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Alva Clarence Henderlite
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 Married
6. (b) Name of husband or wife Lucinda
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 10 (Day) 1873 (Year)

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Randolph, Co. Ill (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name Wesley Henderlite
13. Birthplace Belleville Ill (City, town, or county) (State or foreign country)
14. Maiden name Sarah Harmon
15. Birthplace New Palestine Ill (City, town, or county) (State or foreign country)

16. (a) Informant Lucinda P. Henderlite
(b) Address Farmington Mo

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

18. (a) Signature of funeral director Caldwell Bros
(b) Address Flat River Mo

19. (a) 3-30-44 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27
year 1944 hour 4 minute P M.

21. I hereby certify that I attended the deceased from July 1, 1944, to March 1944
that I last saw him alive on March 27, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Arteriosclerosis	
Due to: Chronic Myocarditis	
Due to: Chronic Nephritis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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)
(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 L. C. Applegate (M. D. or other)
Address Farmington Mo Date signed 3-30-44

1373 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 444-3709

Date Filed 4-12-44

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.A. Caldwell

Licensed Embalmer No. 3317

P. O. Address Flat River 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.