N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Cass

Township: Gallatin

or Village: ~~Harlem~~

or City: (NO. Harlem Mo St.: Ward)

Registration District No.: 197 File No.: 593

Primary Registration District No.: 5276 Registered No.: 39

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Giles Henry Hendgens

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: May (Month) 2 (Day), 1863 (Year)

AGE: 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Section Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): R-100

BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS
NAME OF FATHER: David Hendgens
BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
MAIDEN NAME OF MOTHER: Elizabeth Weech
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas H. Hendgens
(ADDRESS) Harlem

Filed Jan. 3rd 1912 Dr Thomas Wash
By H. M. Dagg REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec 23 (Month) (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 10, 1911, to Dec 22, 1911, that I last saw him alive on Dec 22, 1911, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

53E Cancer of neck

(Duration) 2 yrs. 1 mos. ds.

Contributory (SECONDARY) none

(Duration) yrs. mos. ds.

(Signed) H. M. Dagg M. D.

Dec 23 1911 (Address) Harlem

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: German Church

DATE OF BURIAL: 12-25 1911

UNDERTAKER: Taylor Bros

ADDRESS: 1421 Main K C Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HI
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....(NO.....,.....St.:.....Ward)

Registration District No..... File No.....

Primary Registration District No..... Registered No.....

[If death hospital or give its N of street and

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

.....(Month) .....(Day) I.....(Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed.....,191....,.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....(Month) .....(Day)

I HEREBY CERTIFY, that I attended decea

.....,191....,to.....

that I last saw h.....alive on.....

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.

(Signed).....

.....,191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Ca (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURI
UNDERTAKER	ADDRESS