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.

UNFADING INK—THIS IS A PERMANENT REC...

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

PLACE OF DEATH

County Cape Girardeau

Township do

or

Village

or

City Cape Girardeau (NO. Good Hope St. St.: 4 Ward)

Registration District No. 125

Primary Registration District No. 3009

File No. 40796

Registered No. 1739

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

FULL NAME William H Henson.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH: December 1, 1917 (Month) (Day) (Year)

AGE: ___ yrs. ___ mos. 30 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) 9 10 A

BIRTHPLACE (City or town, State or foreign country) Cape Girardeau Mo.

PARENTS

NAME OF FATHER: R. B. Henson

BIRTHPLACE OF FATHER (City or town, State or foreign country): Jackson County Illinois

MAIDEN NAME OF MOTHER: Millie Brown.

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Madison County Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. B. Henson

(ADDRESS) Cape Girardeau Mo

Filed 1/1, 1918. R. W. Trissell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: December 31, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from December 31, 1917, to December 31, 1917, that I last saw him alive on December 31, 1917, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ___ yrs. ___ mos. 5 ds.

Contributory (SECONDARY) Whooping Cough

(Duration) ___ yrs. ___ mos. 20 ds.

(Signed) R. F. Wichtrich M. D.

January 1, 1918 (Address) Cape Girardeau Mo.

*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: Fairmount Cemetery

DATE OF BURIAL: Jan 1 1918

UNDERTAKER: Walther F. & U. Co.

ADDRESS: Cape Girardeau Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PE

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.

PLACE OF DEATH

County.....

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

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

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

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

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

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (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), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191...., that I last saw h..... alive on ....., 191.... and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory (SECONDARY) .....

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

(Signed) ..... M. D.

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

*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	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS