Stewart.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

3513

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

1. PLACE OF DEATH
County: Bates — Registration District No.: 50 — File No.:
Township: — Primary Registration District No.: 3004 — Registered No.: 201
City: Butler (No. , St. Ward)

2. FULL NAME: Lyman Hensley
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (or WIFE OF): May Hensley

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 22 1876

7. AGE: Years 48 — Months 1. — Days 3 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stock buyer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Bates Co.
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: Cole Hensley
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Kentucky
12. MAIDEN NAME OF MOTHER: Mary Jane Holly
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Mt. Sterling
(STATE OR COUNTRY): Kentucky.

14. INFORMANT: S. B. Hensley
(Address): 321 E. 6th St. K.C. Mo

15. FILED: Feb 27 1924 — T. F. Lockwood, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): February 25 1924

17. I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1924, to Feb. 25, 1924, that I last saw him alive on Feb. 25, 1924, and that death occurred, on the date stated above, at 1:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy Cerebral hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): High Blood Pressure
(duration) 15 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) T. F. Lockwood, M. D.
, 19 (Address) Butler Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Oak Hill — DATE OF BURIAL: Feb. 27 1924
20. UNDERTAKER: Culver's — ADDRESS: Butler Mo

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

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

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

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

City..... (No..... ..... St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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