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

Do not use this space.

18272

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1007 — Registered No. 2315
City Kansas (No. Old City Hospital St. Ward)

2. FULL NAME James Henderson
(a) Residence. No. 1317 W 24th St., B Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 65 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: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unk. 1870

7. AGE 65 YEARS 57 — MONTHS — DAYS — If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) Missouri

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Millie Henderson (Address) 1317 W. 24th

15. FILED 6/10, 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/7 1927

17. I HEREBY CERTIFY, That I attended deceased from 5 — 30 —, 1927, to 6 — 7 —, 1927 that I last saw him alive on 6 — 7 —, 1927, and that death occurred, on the date stated above, at 10.14 P. m.

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

CONTRIBUTORY (SECONDARY) Myocarditis Chr
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 906
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Microscopical
(Signed) H. M. Smith, M. D
6, 8, 1927 (Address) Old City Hospital.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Maple Hill — DATE OF BURIAL: 6/11 1927

20. UNDERTAKER: Watkins Bros — ADDRESS: 1729 Lydia

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.