

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

Do not use this space.

21277

AUG 16 1927

**1. PLACE OF DEATH**

County..... Bron  
Township..... Areadia  
City..... (No.....)..... St..... Ward.....

Registration District No..... 391  
Primary Registration District No..... 5546a

File No.....  
Registered No..... 29

**2. FULL NAME** Aline Henson

(a) Residence. No..... Bron County Mo...... Ward.....  
(Usual place of abode)

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..... Female  
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..... George Henson

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

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	22	11	21	

**8. OCCUPATION OF DECEASED**

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

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

10. NAME OF FATHER..... John Wells

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

12. MAIDEN NAME OF MOTHER..... Black

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

14. INFORMANT..... John Wells  
(Address)..... Knob Lick Mo

15. FILED..... 7/19 27 Robert A Rasche  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... July 19 19 27

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:**

Septicemia  
dead foetus  
14 1/2 H  
14 6  
14 3/4 A..... (duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY)..... uraemia..... (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED..... 14301  
IF NOT AT PLACE OF BIRTH.....

DID AN OPERATION PRECEDE DEATH..... no DATE OF.....  
WAS THERE AN AUTOPSY?..... no

WHAT TEST CONFIRMED DIAGNOSIS.....  
(Signed)..... Geo Farrar..... M. D.

7/19, 1927 (Address)..... Leonton 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... Knob Lick Mo  
DATE OF BURIAL..... July 20 19 27

20. UNDERTAKER..... Bond + White  
ADDRESS..... Leonton Mo.

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

AUG 15 1956

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Iron  
Township Acadia  
City..... (No..... St..... Ward)

Registration District No. 391 File No.....  
Primary Registration District No. 5546 a Registered No. 29

**2. FULL NAME**

Aline Henson

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 28 - 1904

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)

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

9/9 27 Roberta Ranche  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1927

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

PHYSICIANS should show this to the Registrar. Information should be carefully supplied. AGE should be stated EXACTLY. BIRTH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE BY LAW

SUPPLEMENTARY

FE212-5