

JAN 17 1928

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

Do not use this space.

36086

1. PLACE OF DEATH

County Buchanan  
Township St Joseph  
City St Joseph (No. ....) St. .... Ward)

Registration District No. 85  
Primary Registration District No. 1001

File No. ....  
Registered No. 1332

2. FULL NAME

(a) Residence. No. .... St. .... Ward. Lutheran Mo  
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 25 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) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF No

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 3, 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
65 5 1 23

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Cumberland County  
(STATE OR COUNTRY) Pennsylvania

10. NAME OF FATHER James S. Henderson

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

12. MAIDEN NAME OF MOTHER Helen Nickla

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

14. INFORMANT Record of State Hospital No 2  
Address St. Joseph Mo.

15. FILED DEC 27 1927 REGISTRAR John S. [Signature]

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 26, 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 7, 1927, to December 26, 1927 that I last saw him alive on December 25, 1927, and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Hemorrhage  
90B 931  
871  
97  
(duration) yrs. mos. 1 da.

CONTRIBUTORY (SECONDARY) Atherosclerosis + Myocarditis  
(duration) Indefinite yrs. mos. da.

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) R. F. Crank, M. D.

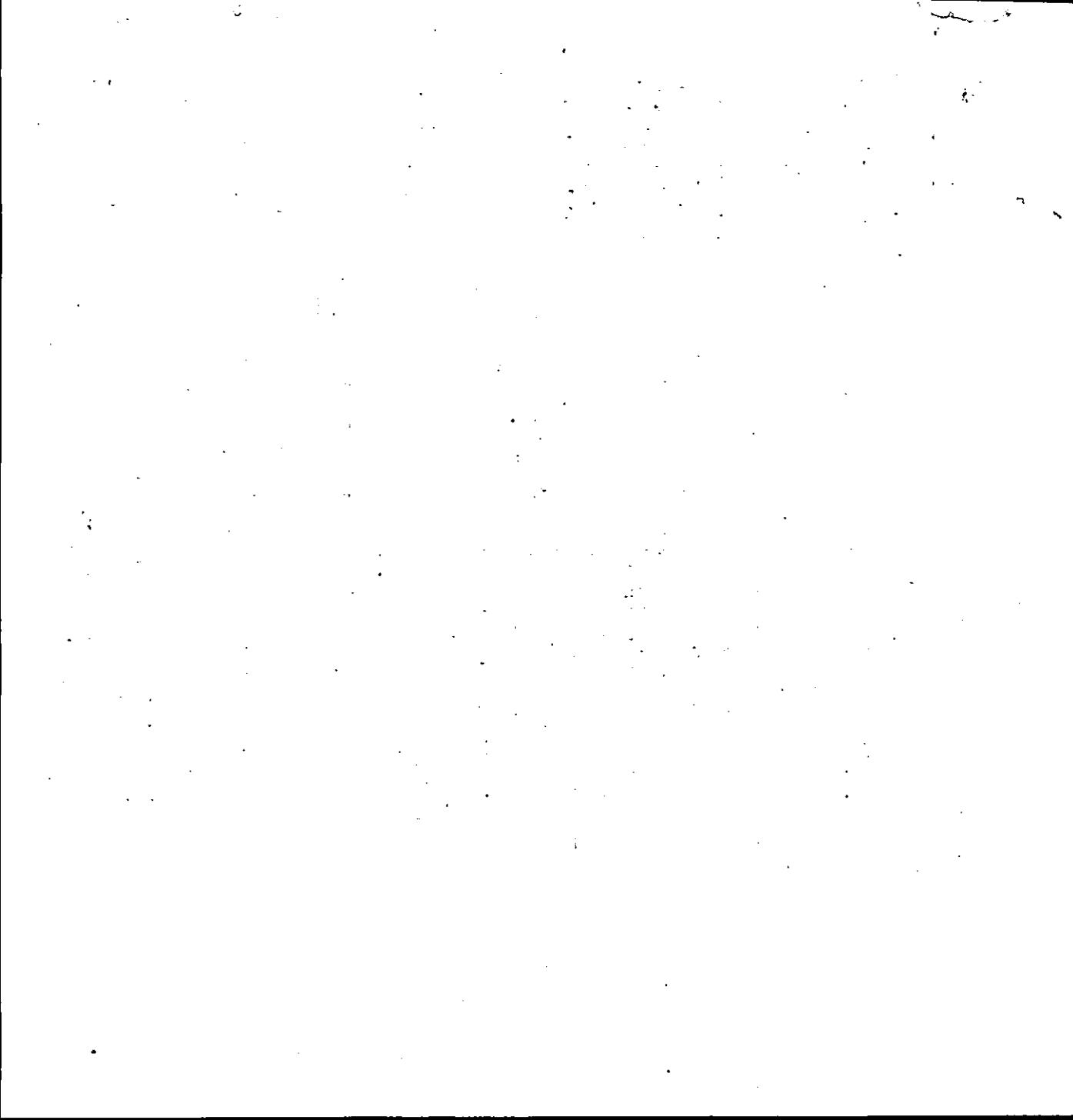
Dec 26, 1927 (Address) State Hospital No 2, St. Joseph, Mo.

\*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 DATE OF BURIAL

Lutheran Mo. 12/27 1927

20. UNDERTAKER ADDRESS St. Joseph Mo.  
St. Joseph Crank



**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 Buchanan Registration District No. 83- File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 1001 Registered No. 1332  
 City St Joseph (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Daniel Jacob Henderson  
 (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** M **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** S  
(write the word)

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** July 3, 1862

**7. AGE** YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
63- 3- 23

**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 1/3 28 1928 John E. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Dec 26 1927

**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) \_\_\_\_\_ m.

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**

19\_\_\_\_

**20. UNDERTAKER**

**ADDRESS**

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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