

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

Do not use this space.

37579

1. PLACE OF DEATH

County *Miller*
Township *Galena*
City *Eldon*

Registration District No. *561*
Primary Registration District No. *4330*

File No. _____
Registered No. *64*
St. _____ Ward _____

2. FULL NAME

Thomas Daniel Henley

(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) *single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 14, 1927*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
14

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) *Eldon, Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *James A. Henley, Mo.*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Miller Co., Mo.*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Myrtle H. Pierce*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Miller Co., Mo.*
(STATE OR COUNTRY)

14. INFORMANT *James A. Henley, Mo.*
(Address) *Eldon*

15. FILED *12-30 1927* *Belle Haynes, Registrar*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec. 28 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Dec 27*, 19*27*, to *Dec 28*, 19*27* that I last saw *him* alive on *Dec 28*, 19*27*, and that death occurred, on the date stated above, at *5 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
1074

(duration) yrs. mos. ds. *1 ds.*

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) *G. J. Walker, M. D.*

.19 (Address) *Eldon Mo.*

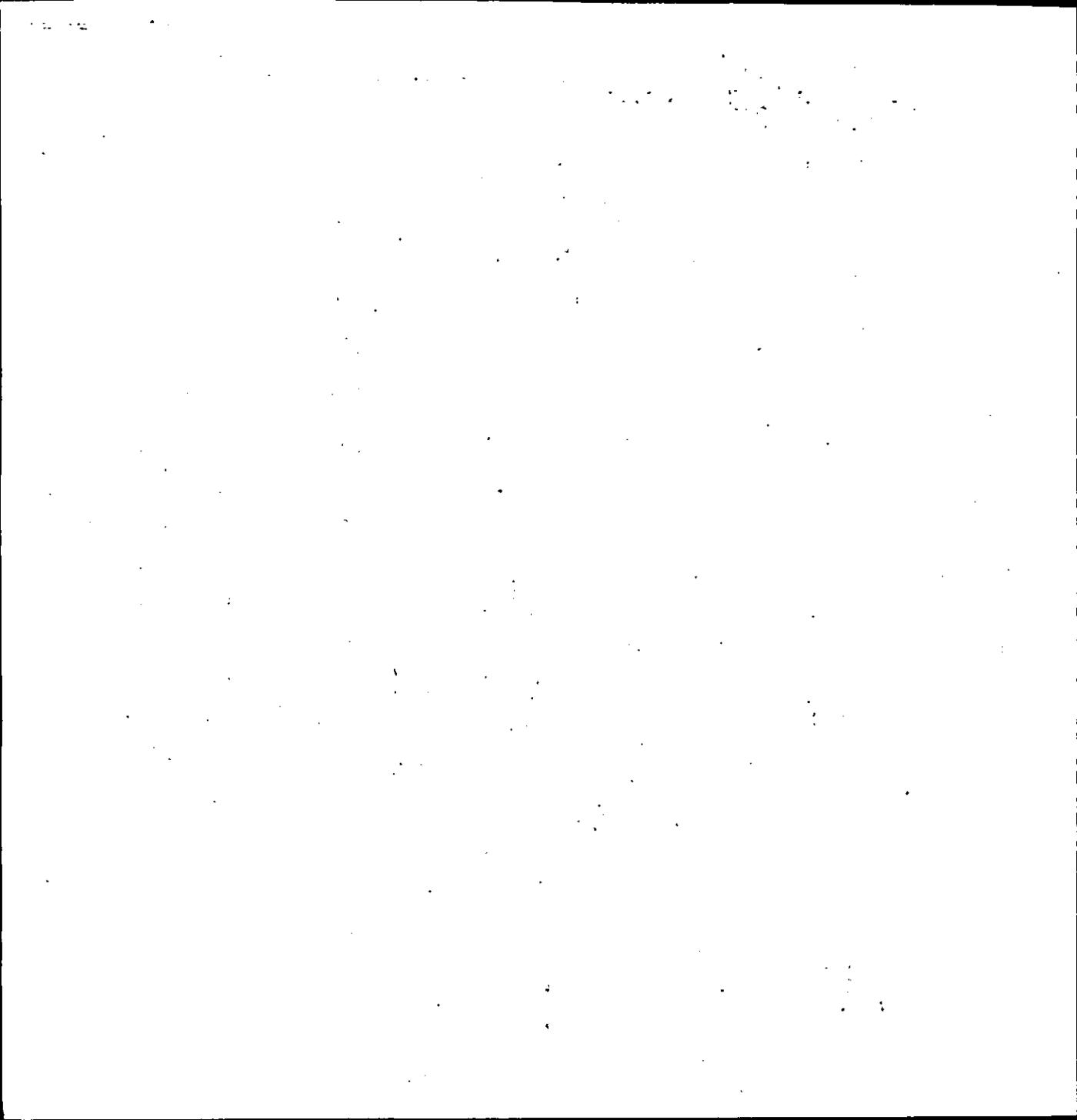
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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

Eugene, Mo. *12-29 1927*

20. UNDERTAKER

W. A. Phillips *Eldon, Mo.*



**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Miller Registration District No. 561 File No. _____
 Township Edon Primary Registration District No. 4330 Registered No. 64
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Thomas Daniel Henley
 (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 (write the word) S

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) _____

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 12-30-27 Belle Haynes. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 28 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 at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Brochial Pneumonia

Primary (duration) yrs. mos. ds. X

CONTRIBUTORY (SECONDARY) 1000 (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) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

67575-5