FEB 21 1928

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

Do not use this space. 1831

X

1. PLACE OF DEATH

County Marion — Registration District No. ~~909 S. Arch~~ 547 — File No.

Township Mason — Primary Registration District No. 3079 — Registered No. 349

City Hannibal (No. 909 S. Arch St. 5 Ward)

2. FULL NAME Louis Henderson

(a) Residence. No. 909 S. Arch St., 5th 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.

40-10-10

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 22-1887

7. AGE: 41 Years — Months: 11 — Days: 10 — 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): Cement Plant

(c) Name of employer

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

PARENTS

10. NAME OF FATHER James Henderson

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

12. MAIDEN NAME OF MOTHER Harriet Dudley

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

14. INFORMANT Mrs. Ida Porter (Address) Springfield Ill

15. FILED Jan 7 1928 C E Strode REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 2 - 1928

17. I HEREBY CERTIFY, That I attended deceased from 4:45 p.m. Jan 27, 1927 to Jan 2 - 1927 that I last saw h..... alive on Jan 2, 1927, and that death occurred, on the date stated above, at 4:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) Nephritis

(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) H B M Meghan, M. D

1/3/27 19 (Address) 1217 Church

*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: Robinson Cemetary — DATE OF BURIAL: Jan. 5 1928

20. UNDERTAKER: Geo. E. Roberts — ADDRESS: Hannibal

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 Marion — Registration District No. 547 — File No. 1

Township — Primary Registration District No. 3029 — Registered No. 1

City Hannibal (No. ..., ... St. ..... Ward)

2. FULL NAME Louis Henderson

(a) Residence. No. 909 S. Arch St., 5 Ward. (If nonresident give city or town and State)
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M.	B.	D.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 22 - 1887

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
X	40 X	10 X	10	

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. X FILED 1/7 1928 C E Strode Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 1928.

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.

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

SUPPLEMENTARY

...rmation should be carefully ... PHYSICIANS should state ... OF DEATH in plain terms, so that it may be proper... classif... ...ment of OCCUPATION is very important.

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

S-1831