

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

Do not use this space.

12650

1. PLACE OF DEATH

County Clay

Registration District No. 201

File No. _____

Township L. Spring Mo

Primary Registration District No. 5280

Registered No. 31

City (No. _____) _____

St. _____ Ward _____

2. FULL NAME

Travis Lee Hambrick Jensen

(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)

Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 19th 1849

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>79</u>				

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Farman N.Y.

10. NAME OF FATHER D.H. Jensen

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

12. MAIDEN NAME OF MOTHER Wes

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

14. INFORMANT (Address) Mrs. Dan B. Field Liberty Mo

15. FILED 9/18/19 W. H. Madison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/7 1928

17. I HEREBY CERTIFY, That I attended deceased from East
from York 19 to April 7 1928
that I last saw him alive on April 6 1928, **and that**
death occurred, on the date stated above, at 10:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Had apoplexy - & Paralysis of Right side
that could not speak or walk, only by
help
2 1/2 hrs (duration) 4 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Paralysis of throat - could
not swallow (duration) _____ yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH. Valista Iowa

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. H. Muller, M. D.
, 19 (Address) Liberty 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 Willisca Iowa **DATE OF BURIAL** 4/9/28 19

20. UNDERTAKER W. H. Madison **ADDRESS** Liberty Mo

78-3-18

29 928

18

**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 Clay

Registration District No. 201

File No.

Township

Primary Registration District No. 3280

Registered No. 31

City Liberty (No.) St. Ward)

2. FULL NAME

Franklin H. Jerome

(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) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 19 - 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 3 19

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)

FILED 5/10/28 W. H. Jackson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 - 9 - 19 28

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..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

20. UNDERTAKER ADDRESS

RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-12660