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

85

Do not use this space.

327

File No. .....

Registered No. 87

1. PLACE OF DEATH

County: Buchanan — Registration District No. 1001

Township: ..... — Primary Registration District No. .....

City: St Joseph (No. Noyes Hospital St. ..... Ward)

2. FULL NAME: Herbert Marion Henson

(a) Residence. No. 1324 Doy (Usual place of abode) St., ... Ward. ..... (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): July 9 1928

7. AGE: Years 0 | Months 6 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(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): St Joseph Mo

PARENTS

10. NAME OF FATHER: Robert Henson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Nashville Tenn

12. MAIDEN NAME OF MOTHER: Lolita Roberts.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Nashville Tenn

14. INFORMANT: Robt Henson
(Address): 1324 Doy St

15. FILED JAN 21 1929, 19..... John G. Koch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 19 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1929, to Jan. 19, 1929, that I last saw him alive on Jan 19, 1929, and that death occurred, on the date stated above at 12:25 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia 8 10

SPA 10 7

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY): Infantile Cerebral Paralysis

(duration) ..... yrs. ..... mos. 3 ds.

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? Phys. Examination

(Signed) E. V. Thielhoff M. D

Jan. 21, 1929 (Address) 822 Edmond St.

*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: City Cem — DATE OF BURIAL: Jan 21 1929

20. UNDERTAKER: Fleeman Funeral Home — ADDRESS: 1208 Francis

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.

WRITE PLAINLY, WITH BALLPOINT PEN. THIS IS A PERMANENT RECORD