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

Do not use this space.

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1. PLACE OF DEATH

County Greene Registration District No. 318 File No.

Township Primary Registration District No. 2001 Registered No. 223

City Springfield (No. 911 Thomas St. Ward)

2. FULL NAME Alfonzo N. Henry

(a) Residence. No. 911 Thomas 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 wh

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

5a. If Married, Widowed, or Divorced HUSBAND of (or) WIFE of Sadie Henry

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 5-1846

7. AGE Years 82 Months 10 Days 29 If LESS than 1 day, ...hrs. or ......min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retd
(b) General nature of industry, business, or establishment in which employed (or employer) farmer
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Wm Henry

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

12. MAIDEN NAME OF MOTHER Unknown Cain

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

14. INFORMANT Mrs. H. W. Johnson (Address) Springfield Mo.

15. FILED 3-11 1929 J. W. C. Horst M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/4 1929

17. I HEREBY CERTIFY, That I attended deceased from ......, 19...., to ......, 19.... that I last saw h.im alive on Jan 22 1929, and that death occurred, on the date stated above, at ... AM.

THE CAUSE OF DEATH* was as follows: At that time he was suffering from chronic Nephritis, Arteriosclerosis and mitral insufficiency. He died in a state of ... His death was not unexpected. [illegible]
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arterio-Sclerosis
(duration) yrs. mos. ds.

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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) W. D. Dalgleish M.D

3/9, 1929 (Address) Springfield 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 Maple Park

DATE OF BURIAL 3/5 1929

20. UNDERTAKER Alma Lohmeyer

ADDRESS SPRINGFIELD, MO.

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.

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