

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

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PLACE OF DEATH

County Cape Girardeau Registration District No. 125
Township Cape Girardeau Primary Registration District No. 3009
City Cape Girardeau No. Hospital

File No. _____
Registered No. 103
St. _____ Ward)

2. FULL NAME

Miss Mary Pruitt Hensler

(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 _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

Female white married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1902-9-8

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>27</u>	<u>9</u>	<u>17</u>		

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Burke Pruitt

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

12. MAIDEN NAME OF MOTHER Sarah Taylor

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

14. INFORMANT Robert Hensler
(Address) Bloomfield Mo

15. FILED 1/20, 1929 W.C. Kempfer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-20 1929

17. I HEREBY CERTIFY, That I attended deceased from 4-17-29 to 4-20, 1929
that I last saw h. ex alive on 4-20, 1929 and that death occurred, on the date stated above, at 3:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gangrenous Appendicitis

CONTRIBUTORY (SECONDARY) MI (duration) _____ yrs. _____ mos. 12 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, Stoddard Co. Mo.

DID AN OPERATION PRECEDE DEATH? yes DATE OF 4-17-29

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Operation
(Signed) Edward Walker M. D.

4-20, 1929 (Address) Cape Girardeau 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

Gravel Hill Cem. DATE OF BURIAL 4-21 1929

20. UNDERTAKER J. A. Chiles Bloomfield
ADDRESS

1948

1948

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**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 Poplar Grove

Registration District No. 125

File No. _____

Township _____

Primary Registration District No. 3089

Registered No. 103

City _____ (No. _____)

St. _____ Ward _____

2. FULL NAME

Mrs Mary O. Hensen

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-8-1902

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
26 3 12

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 68 29 W. K. Kump REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-20 1929

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:

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

ST. LOUIS, MO.

1914

THE NATIONAL BUREAU OF INVESTIGATION

WASHINGTON, D. C.

REPORT OF SPECIAL AGENT IN CHARGE

OF THE ST. LOUIS OFFICE

IN CONNECTION WITH THE

RECENT BOMBING OF THE

ST. LOUIS POST-OFFICE

ON APRIL 15, 1914

BY ALFRED W. BROWN

AND OTHERS

CHARGE OF BOMBING

OF THE ST. LOUIS POST-OFFICE

ON APRIL 15, 1914

BY ALFRED W. BROWN

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ON APRIL 15, 1914

BY ALFRED W. BROWN

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