

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

Do not use this space.

1. PLACE OF DEATH

791

16204

County.....

Registration District No. 1003

File No. 0244

Township.....

Primary Registration District No. *Bassett, Kinis, Canada Hospital*

City *St. Louis*

2. FULL NAME

Martha Henderson

(a) Residence. No. St. Ward. *11*

Bowling Green Mo.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *7* 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 *Harley Henderson*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 1, 1908*

7. AGE YEARS MONTHS DAYS II LESS than I day, hrs. or min. *21* *28*

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) (STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *J. R. Price*

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

12. MAIDEN NAME OF MOTHER *Emily Turner*

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

14. INFORMANT (Address) *R. C. Mc Nyles 3427 Washington*

15. FILED *10 15 29* REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-9-1929*

17. I HEREBY CERTIFY, That I attended deceased from *April 5th*, 19*29*, to *April 9th*, 19*29*, that I last saw her alive on *April 9, 1929*, and that death occurred, on the date stated above, at *2:15 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS: *Sarcoma Pelvis*

53R (duration) yrs. *2* mos. da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *Bowling Green Mo.* IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH. *yes* DATE OF *4/9/29*

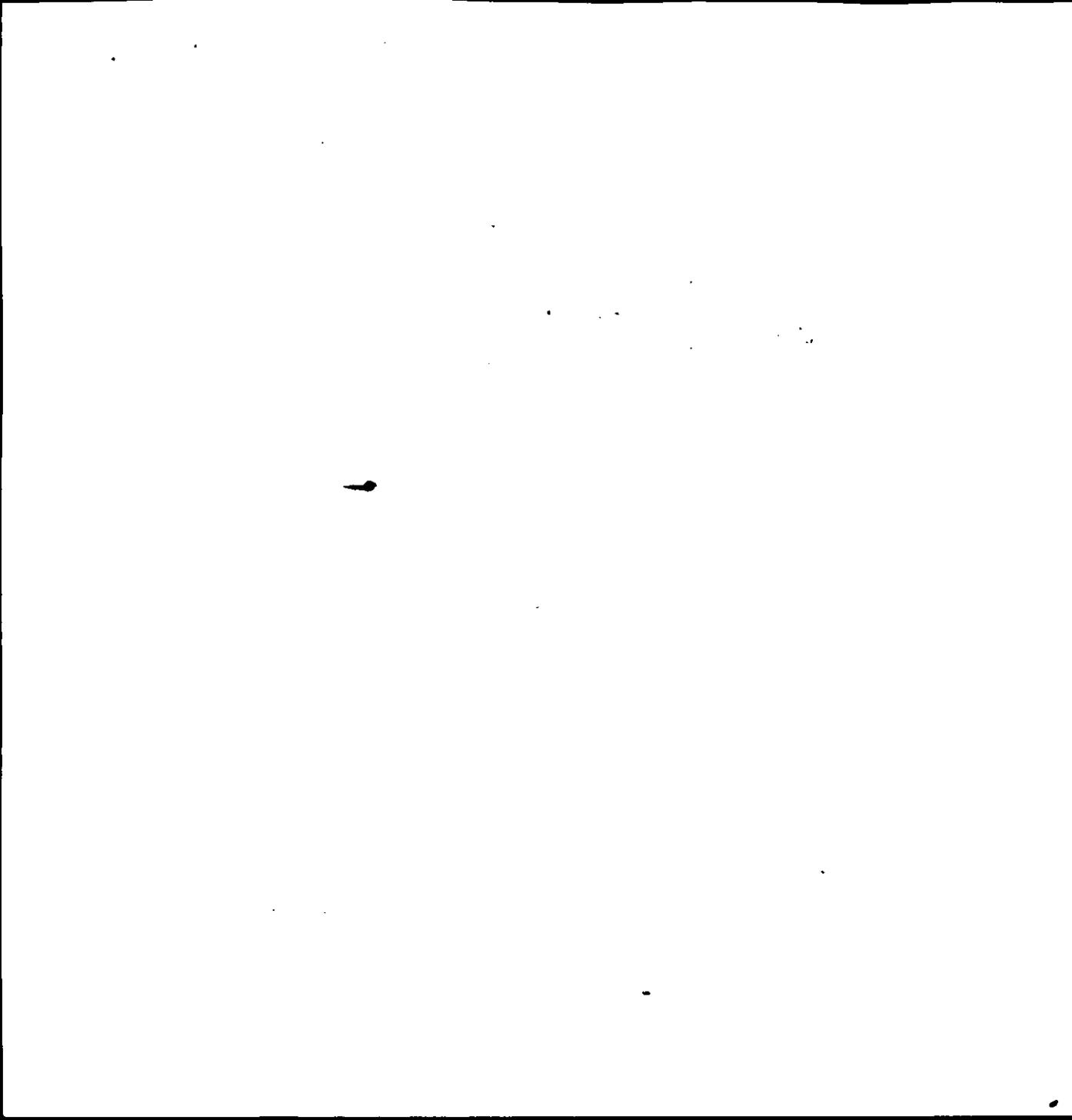
WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Missouri* (Signed) *C. A. Robertson, M.D.* *4/9, 1929* (Address) *3427 Washington*

*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 *Clarksville Mo* DATE OF BURIAL *April 11, 1929*

20. UNDERTAKER *Keesher Ltd Co* ADDRESS *Bowling Green Mo.*



Barward S. + E. North
Je. 3621

ask the physician to state
primary seat of the disease
er cancer, carcinoma,
a, malignant tumor are re-
without qualifications.
sign and return.

1979

Scorpaenidae

**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..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No.) St. Ward)

File No.
 Registered No. 4741

2. FULL NAME Martha Henderson

(a) Residence. No. St. Ward.
 (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. (If nonresident, give city or town and State)

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)

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

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 20 19 1929 Ray C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-9-1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma Pelvis (duration)..... yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Carcinoma of Cervix Uteri (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?..... 49

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) W. A. Roubel Lauson, M. D.

, 19..... (Address) 3427 Washington

*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

SCATTERS