

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

Do not use this space.

24646

3058

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kaw Primary Registration District No. _____
City Kansas City (No. Mercy Hospital Ward) _____

2. FULL NAME

Douglas McHenry
(a) Residence. No. Hickman Mills 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) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 30-29

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
14

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

Hickman Mills Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Jess McHenry

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

12. MAIDEN NAME OF MOTHER Bernadine Jounen

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

14. INFORMANT Mrs. J. P. McHenry

(Address) Hickman Mills Mo.

15. FILED 7-12-29 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 13 1929
17. I HEREBY CERTIFY, That I attended deceased from J. 11 1929 to J. 24 1929
11 1929, to J. 24 1929 and that I last saw him alive on J. 24 1929 and that death occurred, on the date stated above, at 11:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Immature infant
159
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 161W
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) do R. D. Cain, M. D.

2-13, 1929 (Address) Mercy Hospital

*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 Jackson Mo DATE OF BURIAL _____

Ragan Family Cem 7/13/29

20. UMBERTAKER Mrs. C. L. Archer ADDRESS K. C. 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.

