

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

Do not use this space.

31408

1. PLACE OF DEATH

County Monroe Registration District No. 542
Township Jackson Primary Registration District No. 3779
City _____ (No. _____) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Horace Malon Henderson

(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 at his life 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March-6

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	49	5	26	

8. OCCUPATION OF DECEASED

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

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

PARENTS

10. NAME OF FATHER Franklin W. Henderson

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

12. MAIDEN NAME OF MOTHER Mollie Globe

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

14. INFORMANT Mrs. Edna E. Reed
(Address) Maplewood Mo.

15. FILED Sept 4, 1929 H. C. Payne REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 1 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 1, 1929
that I last saw him alive on Sept 1, 1929, and that death occurred, on the date stated above, at 11:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

(duration) 3 yrs. for history

CONTRIBUTORY (SECONDARY) None
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

(1) DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

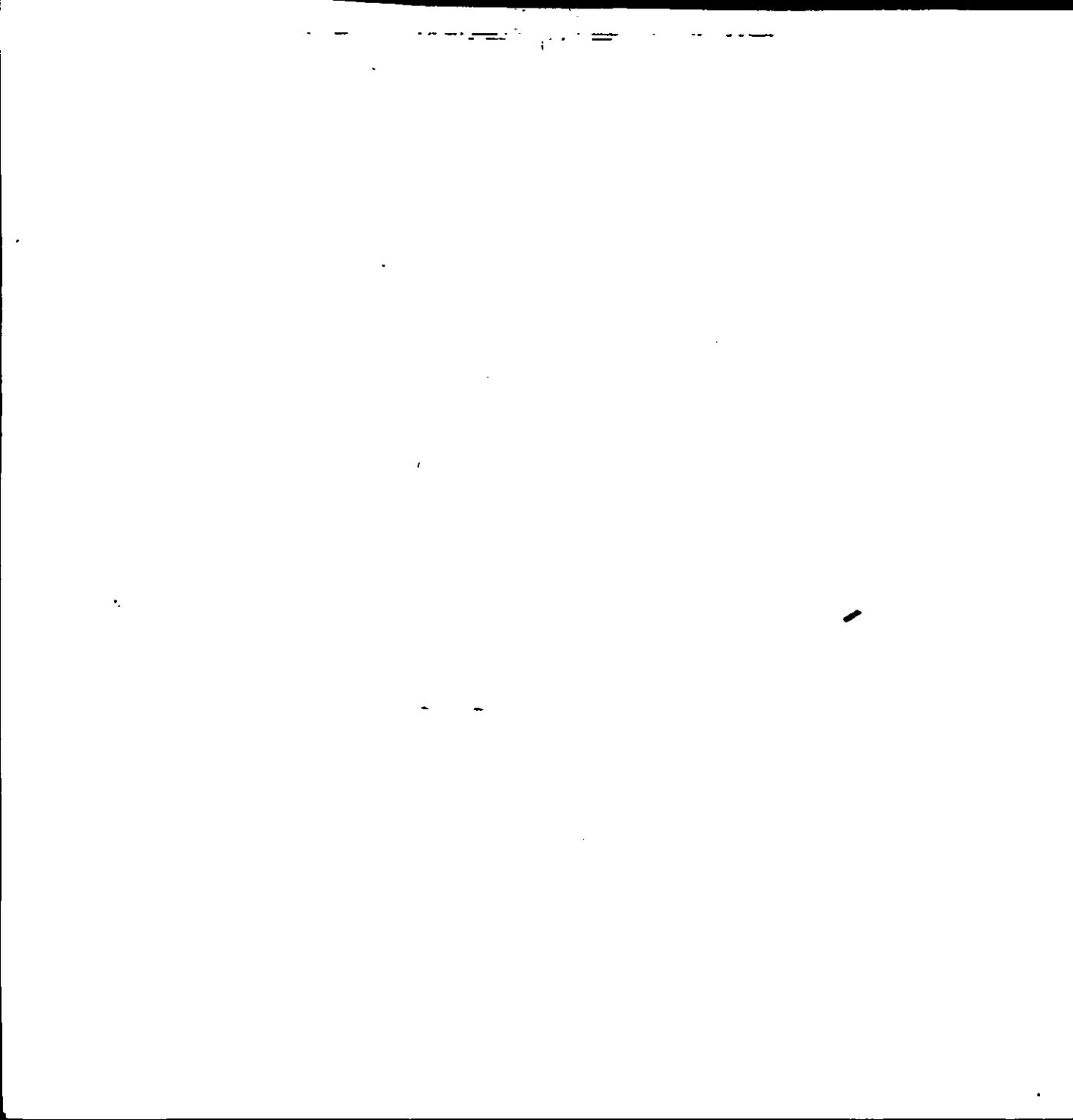
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) M. C. Mc Murry, M. D.

Sept 1, 1929 (Address) Paris 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 - Walnut Grove Cemetery Paris Mo DATE OF BURIAL Sept 4 1929

20. UNDERTAKER Wilson + Son - Monroe City - Mo. ADDRESS _____



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Monroe Registration District No. 582 File No. _____
 Township Jackson Primary Registration District No. 5779 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Horace Malon Henderson
 (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 M 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) March 6 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49 3 1 26

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) _____

PARENTS

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. Sept 4 1929 H.C. Payne
 FILED _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 1 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)

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 _____

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL FILE WITH A FEW COPIES OF THIS SUPPLEMENTARY

S-31408