

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

Do not use this space.

1929

31615

1. PLACE OF DEATH

County Polk Registration District No. 703
Township Johnson Primary Registration District No. 5932
City Juanville (No. 4224)

File No. 1
Registered No. 54
St. _____ Ward _____

2. FULL NAME Wella Henson

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 13 - 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
53 6 16

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) Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Louis Belmont

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

12. MAIDEN NAME OF MOTHER Sally Williams

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

14. INFORMANT P. R. Henson
(Address) Flimination, Mo.

15. FILED Oct. 1, 1929 J. L. Mabry
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 23 to Sept 29, 1929, and that I last saw her alive on Sept 29, 1929, and that death occurred, on the date stated above, at 5:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acidosis following
operation for ovarian
cyst / 11/24
6963 (duration) - yrs. - mos. 6 da.

CONTRIBUTORY (SECONDARY) operation
(duration) yrs. mos. 6 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF Sept 24

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS operation

(Signed) A. J. Dyfflehaus, M. D.

, 19 (Address) Juanville Mo

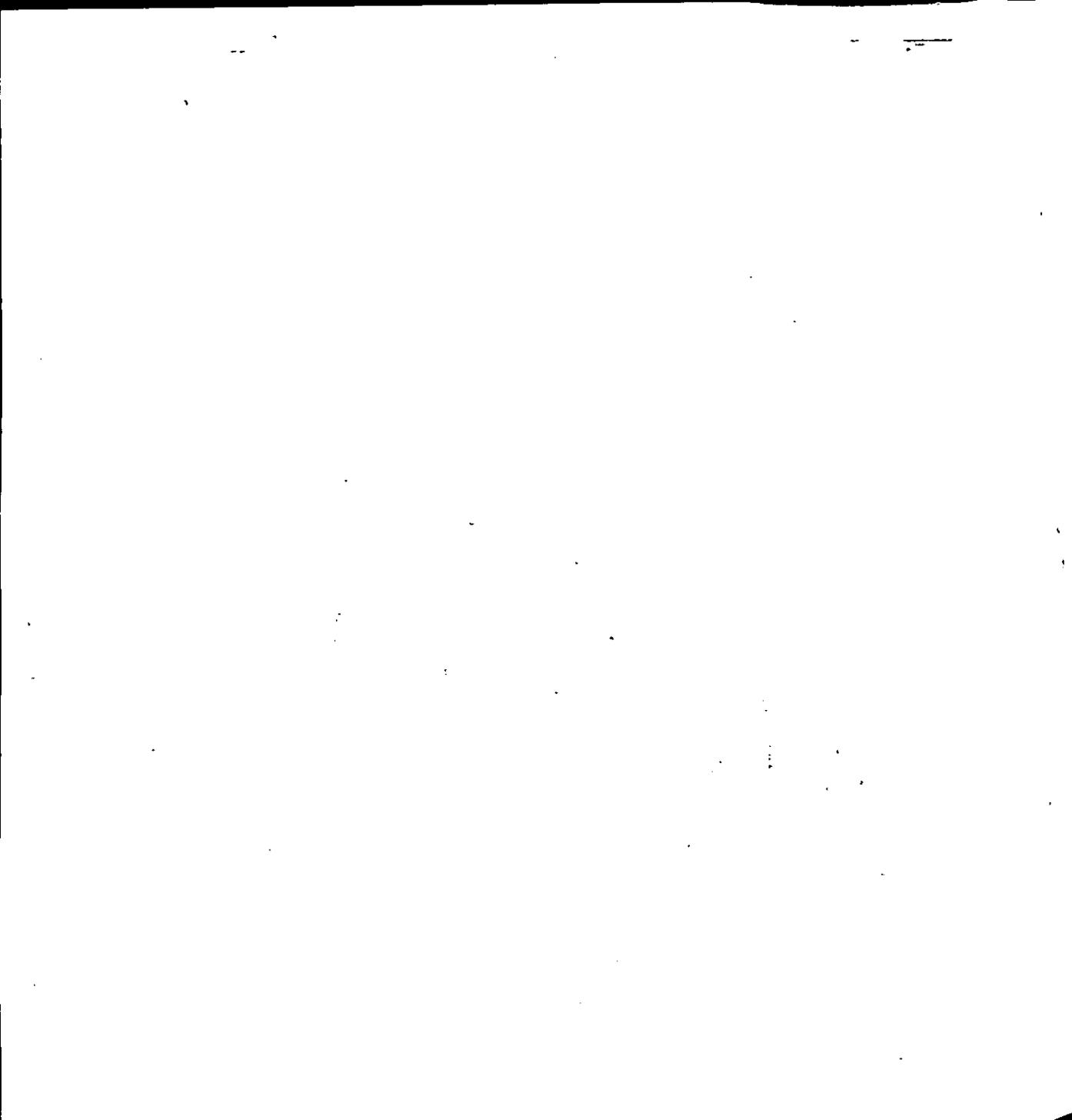
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Tillery Cemetery Oct 1 1929

20. UNDERTAKER ADDRESS

A. A. Joseph 3149



**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 Polk Registration District No. 703 File No. _____
 Townshp Johnson Primary Registration District No. 3932 Registered No. 36
 City _____ (No. _____, St. _____ Ward)

2. FULL NAME

Della Benson

(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 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 10-1-29 J. L. Maby REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 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 listed above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart disease following operation for Ovarian

CONTRIBUTORY (SECONDARY) non diabetic (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

GIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-31015