

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

Do not use this space.

14769

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis, Mo (No. City Hospital #2)

File No.

Registered No. 4178

St. Ward

2. FULL NAME

Jim Henderson

(a) Residence. No. 410 N. Levee St., 25 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 28 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)

Male

Col.

Single

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

—

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-5-1899

7. AGE

YEARS 30

MONTHS 11

DAYS 26

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Odd jobs

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

La.

10. NAME OF FATHER

Ed Henderson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

La.

12. MAIDEN NAME OF MOTHER

Sarah Caldwell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ala.

14. INFORMANT

(Address)

Gertrude Creath
City Hospital #2

15. FILED

APR 27 1930

REGISTER

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-1-1930

17.

I HEREBY CERTIFY, That I attended deceased from 3-24-1930, to 4-1-1930 that I last saw him alive on 4-1-1930 and that death occurred, on the date stated above, at 12:40 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumococic meningitis
108
79A (duration) 8 yrs. 8 mos. 8 ds.
CONTRIBUTORY Lobar Pneumonia
(SECONDARY) (duration) 10 yrs. 10 mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. E. Hale M. D.

4/1/1930 (Address) City Hosp #2

*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

St. Louis U.

4-5 1930

20. UNDERTAKER

ADDRESS

Walter Richter

3510 Rutquist

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.