JUL 23 1930

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

Do not use this space.

19879

File No. ____

Registered No. 1572

1. PLACE OF DEATH
County Laclede
Township ____
City Lebanon (No. ____ St. ____ Ward)

Registration District No. 449
Primary Registration District No. 4267

2. FULL NAME Geo. A. 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. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Black
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct. 13-1861

7. AGE: YEARS 68 | MONTHS 8 | DAYS 29 | 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) Farmington
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ____
(STATE OR COUNTRY) " "
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ____
(STATE OR COUNTRY) ____

14. INFORMANT Bertha Henson
(Address) Lebanon Mo.

15. FILED ____, 19____ ____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 12 1930

17. I HEREBY CERTIFY, That I attended deceased from June 7 —, 1930, to June 12 —, 1930 that I last saw h. alive on June 12, 1930 and that death occurred, on the date stated above, at 2.10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia for
- acute -

107A (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) ____ (duration) ____ yrs. ____ mos. ____ 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) Geo. D. Wendler, M. D.
June 14, 1930 (Address) Lebanon 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: Lebanon Mo. | DATE OF BURIAL: June 14 1930

20. UNDERTAKER: Palmer | ADDRESS: Lebanon

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.

JAN 9 1949

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 Laclede — Registration District No. 449 — File No. .....

Township ..... — Primary Registration District No. 4267 — Registered No. .....

City Lebanon (No. ....., ... St. ..... Ward)

2. FULL NAME Geo A. 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. 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)
M	Col	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)

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. 4 FILED Aug 1930 J M Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 12 1930

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:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (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

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-19879