

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

Do not use this space.

1. PLACE OF DEATH

County Gentry
Township _____
City Albany (No. _____)

Registration District No. 309
Primary Registration District No. 4185

File No. 32731
Registered No. 58
St. _____ Ward _____

2. FULL NAME Mrs. Ella G. Henderson

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

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

James Henderson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 18, 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 6 22

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, STATE OR COUNTRY) Manard Co. Illinois

10. NAME OF FATHER H.W. Goff

11. BIRTHPLACE OF FATHER (CITY OR TOWN, STATE OR COUNTRY) Unknown Ill.

12. MAIDEN NAME OF MOTHER Maria Goldsby

13. BIRTHPLACE OF MOTHER (CITY OR TOWN, STATE OR COUNTRY) Unknown Ill.

14. INFORMANT Mr. James Henderson
(Address) Albany, Mo

15. Oct. 11, 1933 W.T. Martin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 9 1933

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1933, to Oct 7, 1933, that I last saw h. alive on Oct 5, 20, 1933, and that death occurred, on the date stated above, at 5:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

leucemia of Bowel

unknown (duration) 1 yrs. 6 mos. 2 ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. ✓

19. DID AN OPERATION PRECEDE DEATH? no DATE OF ✓

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) J.E. Graham, M. D.

, 19 (Address) Albany - 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 Grandview DATE OF BURIAL Oct. 11 1933

20. UNDERTAKER Clifford Brooks ADDRESS Albany, Mo.

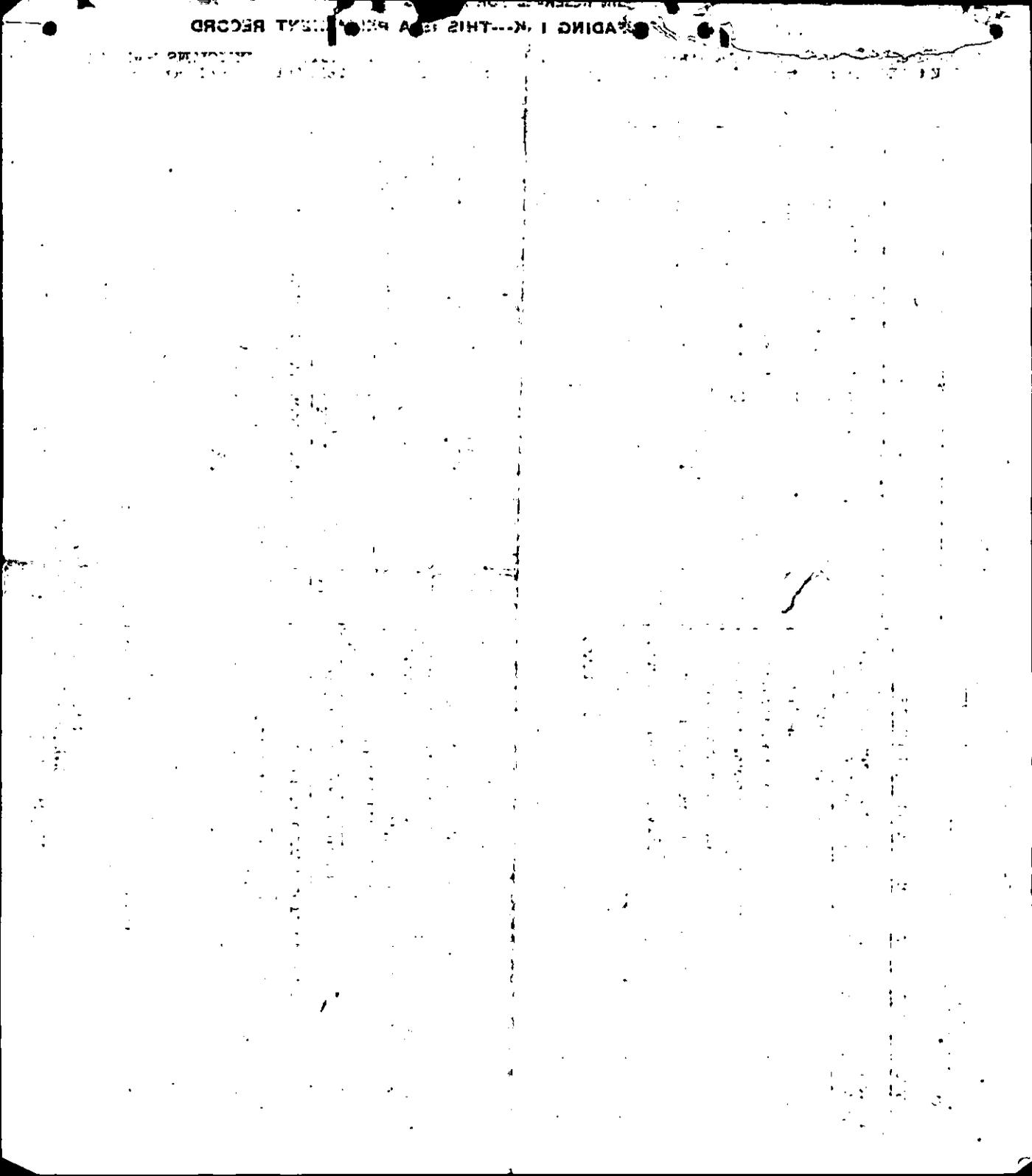
WRITE PLAINLY WITH FADING INK---THIS IS A PERMANENT RECORD

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.

NOV 10 1933

RECORDING UNIT

19



**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 Cass

Registration District No. 309

Township

Primary Registration District No. 4185

City Albany (No.)

File No.

Registered No.

St. Ward)

2. FULL NAME

Lella 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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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.
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OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED Nov. 29, 1933 W. T. Martin Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 9, 1933

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on, 19... Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

laceration of bowels Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed), M. D.

(Address)

SUPPLEMENTARY

FADING IN THIS IS A PERMANENT RECORD

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 COMPLETED AS PRESCRIBED BY LAW.

S-32731