

FEB 27 1934

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

Do not use this space.

1714

1. PLACE OF DEATH

County Laclede Registration District No. 449
Township Springfield Primary Registration District No. 5615
City (No.) St. Ward

2. FULL NAME Elijah Henson

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 4 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 8 17

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

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) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede, Mo

13. NAME Joseph Henson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Barbory Pulce

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT Burley Henson

18. BURIAL, CREMATION, OR REMOVAL buried

19. UNDERTAKER Wheeler Stewart

20. FILED 19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 21 1934

22. I HEREBY CERTIFY, That I attended deceased from

0, 1900, to 0, 1900. I last saw him alive on 0, 1900. Death is said

to have occurred on the date stated above, at 10 a.m.

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

Apoplexy

Other contributory causes of importance:

Name of operation Date of What test confirmed diagnosis? Was there an autopsy? no

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? no If so, specify

(Signed) O. C. Wenzel, M. D. (Address) Conway Mo.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Laclede Registration District No. 449
 Township Springholloae Primary Registration District No. 6613
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Religie Hinson
 (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.

File No. 1714
 Registered No. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>		4. COLOR OR RACE <u>w</u>		5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>	
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.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.				
	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)		11. Total time (years) spent in this occupation		
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 <u>1/22/34</u> 19__ <u>J. A. M. Corb</u> Registrar					

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 21 1934

22. I HEREBY CERTIFY That I attended deceased from _____, to _____, 19____.

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:
Cerebral epilepsy

Date of onset 1/10/32

Other contributory causes of importance:
8221

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
 Certificate

h1415