

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

25 1934

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.

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

Do not use this space.

2837

1. PLACE OF DEATH

County Buchanan
Township
City St Joseph (No. State Hospital #2)

Registration District No. 85
Primary Registration District No. 1001

File No. 7897
Registered No. 303
St. _____ Ward _____

2. FULL NAME

Oscar Henderson

(a) Residence, No. _____ St., _____ Ward. Kansas City Mo.
(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 Male	4. COLOR OR RACE white	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) unknown
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1881 unknown		
7. AGE YEARS 52	MONTHS unknown	DAYS unknown
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. unknown		
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) unknown Unknown		
13. NAME Marshall Henderson		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown Kentucky		
15. MAIDEN NAME Mary Williams		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown Texas		
17. INFORMANT (ADDRESS) Records State Hosp #1 St Joseph Mo		
18. BURIAL, CREMATION, OR REMOVAL (PLACE) St Joseph Mo. DATE 3-14 1934		
19. UNDERTAKER (ADDRESS) H. O. Sidenfaden St Joseph Mo.		
20. FILED 3-14 1934 John R Bauder Registrar.		

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 12 1934
22. I HEREBY CERTIFY, That I attended deceased from April 1 1929 to March 12 1934
I last saw him alive on March 12 1934. Death is said to have occurred on the date stated above, at 2:15 p.m.
The principal cause of death and related causes of importance were as follows:

General Paralysis of Insane
83 over prior attack
Date of onset
Other contributory causes of importance:
Dilatation of Liver & Spleen

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? yes

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) Dr Clayton Smith, M. D.
(Address) State Hospital #2 St Joseph Mo

