

AUG 21 1935

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

Do not use this space.

20723

1. PLACE OF DEATH

County Polk  
Township Wishart  
City (No. ....) (No. ....) (Ward)

Registration District No. 707<sup>a</sup>  
Primary Registration District No. 5-9.36

File No. ....  
Registered No. 6  
St. .... Ward

2. FULL NAME

(a) Residence, No. Gerald Leray Hensley 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

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 30 1935

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

22. I HEREBY CERTIFY, That I attended deceased from June 25, 1935, to July 30, 1935. I last saw him alive on June 25, 1935. Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 3, 1927

to have occurred on the date stated above, at 12:20<sup>PM</sup> m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day: hrs. or min. 8 5 27

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

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.

Mesles complicated by pneumonia & meningitis

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

Other contributory causes of importance:  
None

13. NAME Elmer Hensley

Date of onset 6-23

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Polk Co. Mo.

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

15. MAIDEN NAME Bessie Sloan

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

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Polk Co. Mo.

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

17. INFORMANT (ADDRESS) Elmer Hensley  
Wishart Mo.

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

18. BURIAL, CREMATION, OR REMOVAL PLACE Hickory Grove DATE July 1 1935

Manner of injury .....  
Nature of injury .....

19. UNDERTAKER (ADDRESS) Hatcherson - Blue  
Polk Co. Mo.

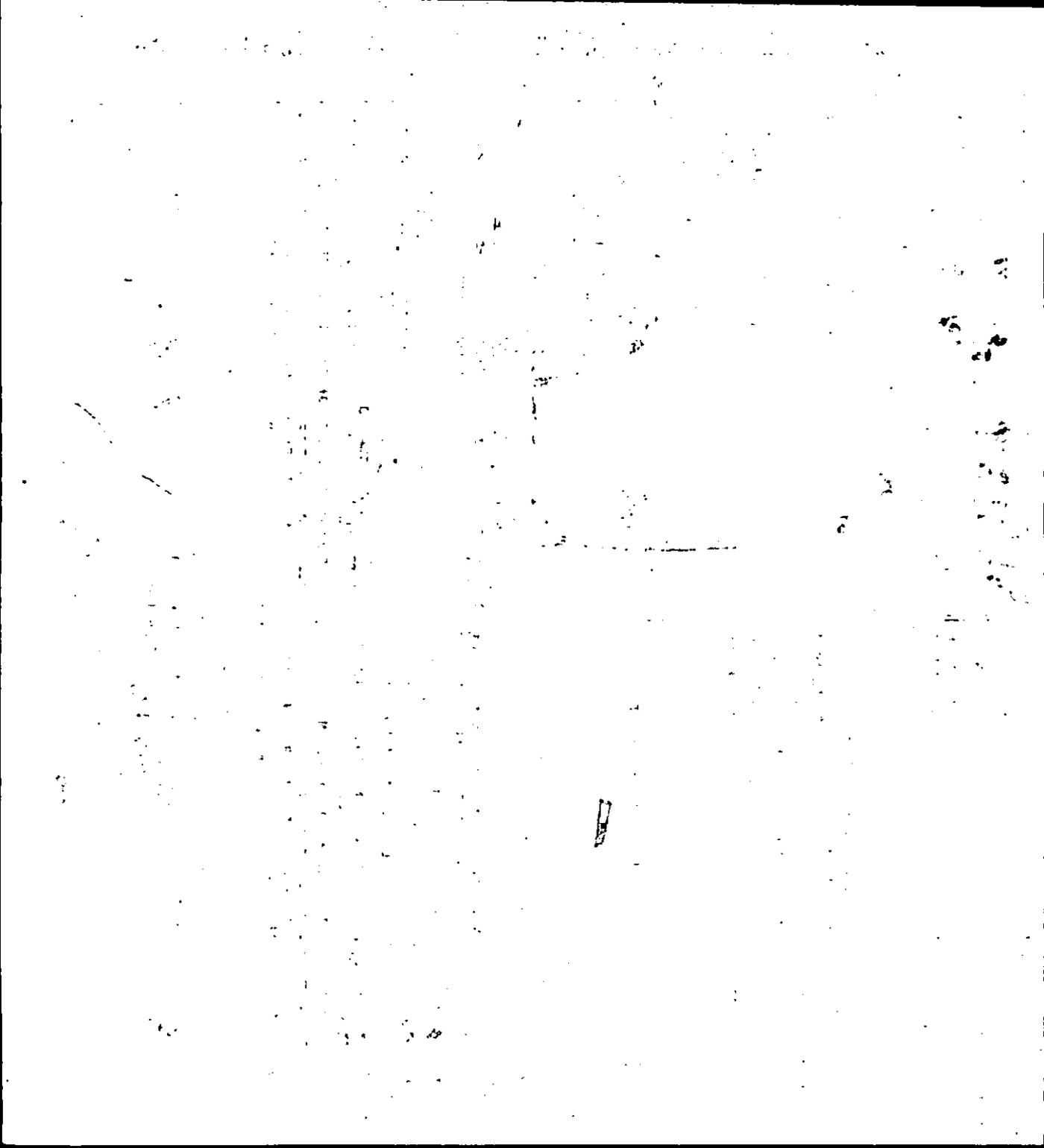
24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify .....

20. FILED July 12 1935 Mrs. Hattie M. Taylor  
Registrar

(Signed) Doy C. M. Sloan M. D.  
(Address) Polk Co. Mo.

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.

RECORD WITH CHANGING INITIALS IS A PERMANENT RECORD



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

ALL INFORMATION ON THIS SUPPLEMENTARY  
FORM MUST BE WRITTEN ON  
THIS SUPPLEMENTARY  
Do not use this space.

**1. PLACE OF DEATH**

County Polk Registration District No. 707~~02~~ File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 5996A Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Gerald Leray Hinsley

(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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>s</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____		
7. AGE YEARS <u>8</u>	MONTHS _____	DAYS _____
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 he ceased 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 \_\_\_\_\_

FATHER 14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

MOTHER 16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED July 12, 1935 Mrs. Hattie M. Taylor  
 Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 30, 1935

I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
 I first saw him \_\_\_\_\_ 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:

messles, complicated  
by pneumonia &  
meningitis  
non Epidemic meningitis

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) D. L. Mc Crow, M. D.  
 (Address) Bohivar Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. ALL INFORMATION ON THIS SUPPLEMENTARY FORM MUST BE WRITTEN ON THIS SUPPLEMENTARY Do not use this space.

S-20723