

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.

SEP 18 1935

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

Do not use this space.

0708

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25637

1. PLACE OF DEATH

County Buchanan

Registration District No. 1001

File No. 853

Township St Joseph

Primary Registration District No.

Registered No. 853

City St Joseph

(No. State Hospital for Insane No. 2 St. Ward)

2. FULL NAME

Mabel Henry

(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 10 yrs. 9 mos. 13 ds. How long in U. S., if of foreign birth? mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 10, 1935

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

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1934, to Aug 10, 1935

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 1886

I last saw h. alive on Aug 9, 1935. Death is said to have occurred on the date stated above, at 3:40 a.m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49 unknown

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. None
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

Cerebro spinal syphilis
Chronic interstitial nephritis
Date of onset Dec 27, 1934

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

Other contributory causes of importance: Arteriosclerosis and Chronic interstitial nephritis

13. NAME unknown

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

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

15. MAIDEN NAME

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

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.

17. INFORMANT (ADDRESS) Records State Hosp #2 or general fund

18. BURIAL, CREMATION, OR REMOVAL PLACE State Hosp for Insane DATE Aug 12, 1935

Manner of injury Nature of injury

19. UNDERTAKER (ADDRESS) H. A. Baker 1326 So. 13th St. Kansas City Mo

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

20. FILED 8-13-35 J. B. Bender Registrar

(Signed) W. Clayton Smith, M. D. (Address) State Hosp for Insane St Joseph Mo

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