

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

33274
Do not use this space.

OCT 18 1939

1. PLACE OF DEATH

(a) County Polk Registration District No. 703
 (b) Township Galesburg Primary Registration District No. 4424 Registered No. _____
 (c) City Humanville (d) Street No. Gen. Dismitt Memorial Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

525 Phylander Reder Henson
 (a) Residence, No. Flemington Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m.</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Della Henson (dead)</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 20, 1874</u>		
7. AGE	YEARS <u>64</u>	MONTHS <u>10</u>
		DAYS <u>10</u>
		IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Farmer</u>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Elkton, Mo. Hickory Co. O</u>	
	13. NAME <u>Wm Conley Henson</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Knoxville Tenn;</u>	
	15. MAIDEN NAME <u>Doris Gibbs</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Knoxville, Tenn.</u>	
17. INFORMANT (ADDRESS) <u>Susan Schroder, Flemington Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Telley Cemetery</u> DATE <u>Sept. 21, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>J. R. Luckey, Whadland Mo.</u>		
20. FILED <u>Sept. 26, 1939</u> <u>Ore M. Rich</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-20, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 31, 1939 to Sept 20, 1939
 I last saw him alive on Sept 20, 1939 Death is said to have occurred on the date stated above, at 9:45 a.m.
 The principal cause of death and related causes of importance were as follows:
Carcinoma of Stomach Liver Date of onset any part ago.

Other contributory causes of importance:
adhesions of bowels & heart bladder Last seen Jan Mo

Name of operation Laparotomy date of 9-21-39
 What test confirmed diagnosis? Physical 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) A. J. Stuppelbauer, M. D.
 (Address) Humanville Mo

WRITE PLAINLY, WITH UNFADING 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.

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RECEIVED

District Health Officer No. 7;

District File Number 7-39-7469

Date Filed 10-11-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *J. Luckey*
Licensed Embalmer No. 2982

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

33274
Do not use this space.

1. PLACE OF DEATH
 (a) County Polk Registration District No. 203
 (b) Township _____ Primary Registration District No. 4424 Registered No. _____
 (c) City Hammonsville (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Phylander Redeed Henson
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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. 64 10 _____

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

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 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. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-20, 1939

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

I last 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:
Carcinoma of stomach
and liver
(Primary Stomach) 11-11-1939
and gall bladder

Other contributory causes of importance:
Arteriosclerosis of bowels
and gall bladder

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) A. J. Stoffelmann, M. D.
 (Address) Hammonsville, Mo.

Local Registrar.

SUPPLEMENTARY

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.

