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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18074

Registration District No. 125 — 1940

Primary Registration District No. 3009

Registrar's No. 179

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: South East Mo. Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days Hospital (Specify whether

In this community 6 Months 7 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cape Gir

(c) City or town Jackson Mo (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Larry O'dell Henson 525

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 11 (Month) 12 (Day) 1939 (Year)

8. AGE: Years 0 Months 6 Days 7 If less than one day hr. min.

9. Birthplace Jackson (City, town, or county) Mo (State or foreign country)

10. Usual occupation Infant

11. Industry or business ✓

FATHER
12. Name Howard O. Henson
13. Birthplace Buckhorn (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Hester Goehman
15. Birthplace Jackson (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature Howard O. Henson

(b) Address Jackson, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 (Month) 21 (Day) 1940 (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director S. C. Crowe

(b) Address Jackson Mo.

19. (a) 5-20-40 (Date received local registrar) (b) Jon Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19 year 1940 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from Feb 15, 1940, to May 19, 1940 that I last saw him alive on May 19, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	4 day
Due to	
Due to	
Other conditions Whooping Cough (Include pregnancy within 3 months of death)	3 Mo

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) 1

Address Jackson Mo Date signed 5-20-40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 2476

P. O. Address.....

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

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