

FILED OCT 24 1944

Primary Registration District No. 5821

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Matthews Mo R #1  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Eng & West Eng  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 35 yr \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME JAMES WILLIAM HENSON

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 married

6. (b) Name of husband or wife Martha 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Aug 25 1870  
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 11 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name J. W. Henson

13. Birthplace Jackson Ill  
(City, town, or county) (State or foreign country)

14. Maiden name Matilda Hilton  
(City, town, or county) (State or foreign country)

15. Birthplace Berry Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Orville Henson  
(b) Address Matthews Mo R #1

17. (a) Burial (b) Date thereof 8-9-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park, Sikeston Mo

18. (a) Signature of funeral director Walah Funeral Home  
(b) Address Sikeston Mo

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid  
(c) City or town Rural 720  
(If outside city or town limits, write "RURAL")  
(d) Street No. Matthews Mo R #1 0  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6  
year 1944 hour 6 minute 30 A . M.

21. I hereby certify that I attended the deceased from Aug 1, 1944, to Aug 6, 1944  
that I last saw him alive on Aug 5, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address Sikeston Mo Date signed 9-20-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1366

(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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo

**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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. No 0  
Registrar's No. 45

Registration District No. 2010

Primary Registration District No. 5921

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Matthew Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME James W. Henson  
3. (b) If veteran \_\_\_\_\_ name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 25 1876  
(Month) (Day) (Year)

8. AGE: Years 73 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name J. W. Henson  
13. Birthplace Jackson Ill  
(City, town, or county) (State or foreign country)  
14. Maiden name Matilda Nelson  
15. Birthplace Barry Co Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Oswell Henson  
(b) Address Matthew, Rural  
17. (a) \_\_\_\_\_ (b) Date thereof 8-9-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director W. H. Henson  
(b) Address Likerton, Mo.  
19. (a) 10-28-44 (b) Nelson Louis Jones  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 25 Year 1944 Hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature E. J. Mearns (M. D. or other) \_\_\_\_\_  
Address Likerton, Mo Date signed 7-20-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STIPPLED

MENTARY

MOTHER FATHER

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

34872