

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.

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

Do not use this space.

MAR 2 1935

2637

1. PLACE OF DEATH

County *St. Francois*
Township *St. Francois*
City *Cloria* (No. St. Ward)

Registration District No. *272*
Primary Registration District No. *4463*

File No. *154*
Registered No.

2. FULL NAME *Mary J. Henson*

(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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Robt. Henson*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Apr. 6 - 1866*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 8 28

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *House wife*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *own home*
10. Date deceased last worked at this occupation (month and year) *1-4-35* 11. Total time (years) spent in this occupation. *48*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Doe Run Mo.*

13. NAME *Eliza B. Smith*

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

15. MAIDEN NAME *Melodie B. Bonds*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Francois Co. Mo.*

17. INFORMANT (ADDRESS) *Robt. Henson Cloria Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Doe Run Mo.* DATE *Jan. 6 1935*

19. UNDERTAKER (ADDRESS) *Caldwell Bros. Doe Run Mo.*

20. FILED *1-14 1935* *E. B. Harker Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 4th 1935*

22. I HEREBY CERTIFY That I attended deceased from *Jan 2nd 1934* to *Jan 4th 1935* last saw her alive on *Jan 4th 1935* 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:
Interstitial Nephritis Date of onset

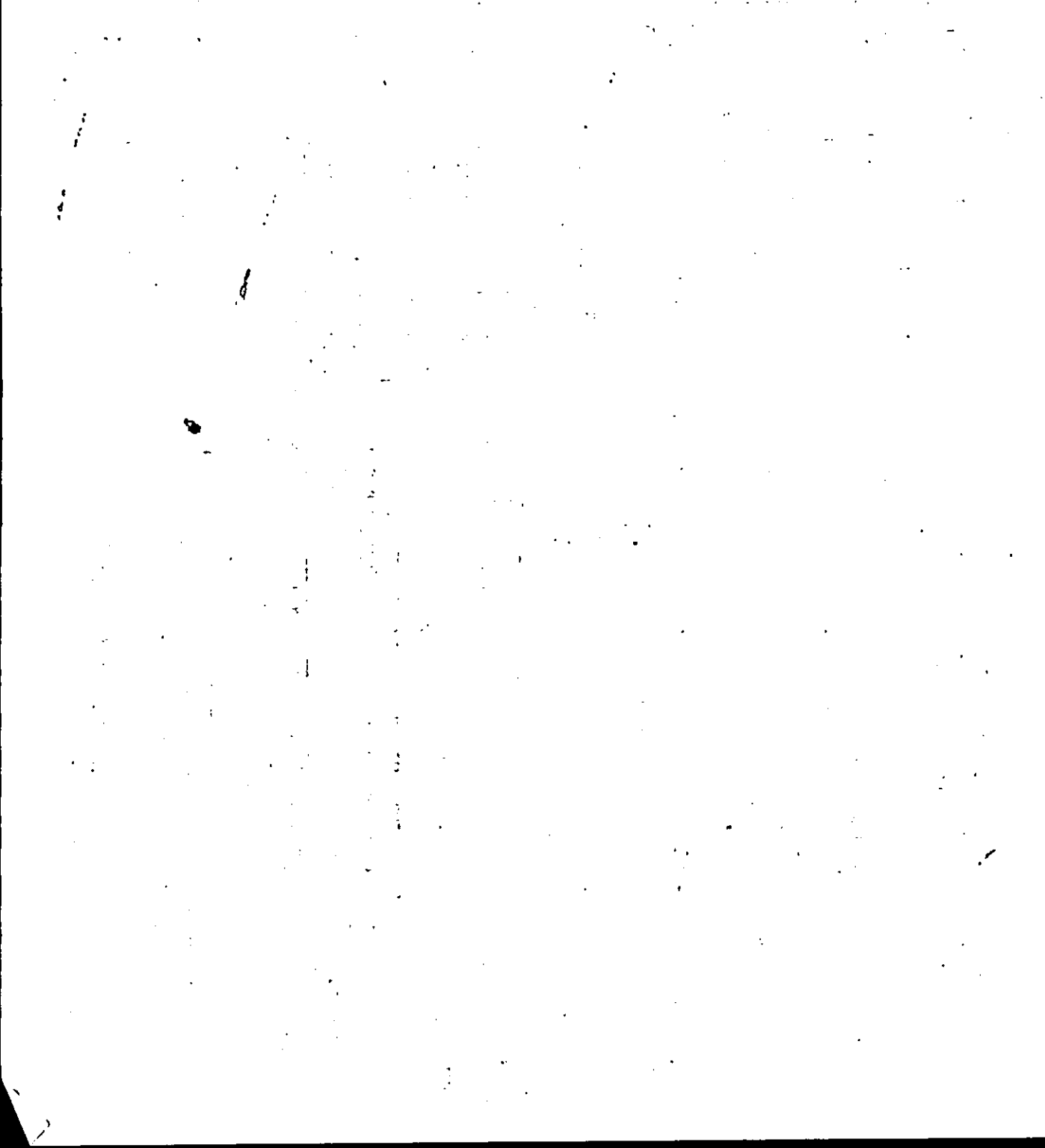
Other contributory causes of importance:
Myo-carditis Burns on feet

Name of operation *none* 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? *No*
If so, specify
(Signed) *Edger E. Whiteside*, M. D.
(Address) *Cloria Mo.*



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Francois
Township.....
City..... (No. St. Ward)

Registration District No. 772-
Primary Registration District No. 4463-

File No. 2637-
Registered No.

2. FULL NAME

Mary L. Henson
(s) Residence, No. St. Ward.
(Usual place of abode)
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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m-

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.

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

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 1-14 1935 C. B. Amos Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 4 - 1935

22. I HEREBY CERTIFY That I attended deceased from

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:

Interstitial Nephritis acute Date of onset 12-15-35

Other contributory causes of importance:

burns on feet

Name of operation none Date of

What test confirmed clinical 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 12-10, 1935

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

Specify whether injury occurred in industry, in home, in street

Her home: House not destroyed

Made after from hot water boiler and hot iron: 2nd & 3rd degree

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Est. Whiteside, M. D.

(Address)

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
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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