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

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

PLACE OF DEATH

County Knox

Township Bee Ridge

or

Village

or

City (NO. St.; Ward)

Registration District No. 441

Primary Registration District No. 5599

File No. 34071

Registered No. 25

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Robert M. Hayes

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Aug (Month) 15 (Day), 1912 (Year)

AGE 3 yrs. 1 mos. 25 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

BIRTHPLACE (City or town, State or foreign country) Bee Ridge Township

PARENTS

NAME OF FATHER William L. Hayes

BIRTHPLACE OF FATHER (City or town, State or foreign country) McDough Co Ill

MAIDEN NAME OF MOTHER Mary Snell

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Knox Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. L. Hayes

(ADDRESS) Edina Mo

Filed Nov 10, 1915 H. J. Jurgens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct (Month) 10 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from July, 1915, to Oct 10, 1915, that I last saw him alive on Aug 8, 1915, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma (of intestine)

40

45

(Duration) ___ yrs. 3 mos. ___ ds.

Contributory (SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Geo S Brown M. D.

Oct 11, 1915 (Address) Edina Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Bee Ridge Cemetry

DATE OF BURIAL Oct 11, 1915

UNDERTAKER Kriegshauser Bros

ADDRESS Edina Mo

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

PLACE OF DEATH

County Knox

Township Bee Ridge

or

Village

or

City (NO. , St.; Ward)

Registration District No. File No.

Primary Registration District No. Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Robert M. Hayes

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word): Single

DATE OF BIRTH: Aug 15, 1912 (Month) (Day) (Year)

AGE: 3 yrs. 1 mos. 28 ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country): Bee Ridge Tenant

PARENTS

NAME OF FATHER: William L. Hayes

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill

MAIDEN NAME OF MOTHER: Mary Ancle

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Knox Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [illegible]

(ADDRESS)

Filed , 191 , REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH , 191 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from , 191 , to , 191 , that I last saw h alive on , 191 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) M. D.

, 191 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL , 191

UNDERTAKER

ADDRESS

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.