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.

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

84461

PLACE OF DEATH

County Pettis D. Campbell

Township ____ or Village ____ or City Sedalia (NO. ____ ____ St.: ____ Ward)

Registration District No. 668 File No. ____

Primary Registration District No. 3032 Registered No. 274

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

FULL NAME Wilma Hayes

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
female	white	single

DATE OF BIRTH: May 23d (Month) (Day), 1913 (Year)

AGE: 2 yrs. 5 mos. 20 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): none

BIRTHPLACE (City or town, State or foreign country): Kansas

PARENTS
NAME OF FATHER: R. B. Hayes.
BIRTHPLACE OF FATHER (City or town, State or foreign country): U. S. a.
MAIDEN NAME OF MOTHER: Genty
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Texas

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Capt. J. T. Williamson

(ADDRESS) Sedalia Mo

Filed Nov 13, 1915 H. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 11 (Month) — 12 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from 11-12-, 1915, to 11-12-, 1915, that I last saw her alive on 11-12-, 1915, and that death occurred, on the date stated above, at 11:30 p m.

The CAUSE OF DEATH* was as follows:

Heart failure from Diphtheria 6d

(Duration) ____ yrs. ____ mos. 10 ds.

Contributory (Secondary) Diphtheria

(Duration) ____ yrs. ____ mos. 10 ds.

(Signed) D. Campbell M. D.

11-12-1915 (Address) Sedalia 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	DATE OF BURIAL
Sedalia Mo	Nov 13, 1915
UNDERTAKER	**ADDRESS**
McLaughlin Bros	Sedalia

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ St.; _____ Ward)

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

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____ (Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

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

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(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

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