LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

38089

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. 1543

City..... (No. 5370 Pershing Ave., St. ..... Ward)

2. FULL NAME William Johnson Haynes

(a) Residence. No..... St., 9 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Sallie Poling Haynes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 16, 1851

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
72	9	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work V. Pres. Hayes Sargently Mfg. Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Furnace Manf'g.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mt. Airy
(STATE OR COUNTRY) N. C.

PARENTS

10. NAME OF FATHER Joseph Graves Haynes

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mount Airy
(STATE OR COUNTRY) North Carolina

12. MAIDEN NAME OF MOTHER Elmira Johnson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mount Airy
(STATE OR COUNTRY) North Carolina

14. INFORMANT Daughter, Mrs. H. B. Markham
(Address) 1000 So. 18th. St. Birmingham, Ala.

15. FILED DEC 28 1923 Mae C. Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 20 1923

17. I HEREBY CERTIFY, That I attended deceased from 12-3, 1923, to 12-20, 1923, that I last saw him alive on 12-20, 1923, and that death occurred, on the date stated above, at 12 30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No Date of

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) F. C. Barnes, M. D.

, 19 (Address) 6312 Washington

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Valhalla Cem. DATE OF BURIAL 12/22 1923

20. UNDERTAKER W. T. Alexander ADDRESS 2835 Olive

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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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... .....St. .....Ward)

2. FULL NAME .....

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

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. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)..... ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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.