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

Do not use this space.

32398

OV 20 1927

1. PLACE OF DEATH

County Saline — Registration District No. 796 — File No.

Township — Primary Registration District No. 3038 — Registered No. 131

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

2. FULL NAME William Pat Hayslip

(a) Residence. No. ..... St., ... Ward. (If nonresident give city or town and State)
(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 4, 1926

7. AGE: Years I — Months 0 — Days 12 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(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) Mo.

PARENTS

10. NAME OF FATHER Sam Hayslip
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Lizzie Butler
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT Sam Hayslip
(Address) Marshall Mo

15. FILED 10/18, 1927 D. S. Manning REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 16 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1927, to Oct 16, 1927 that I last saw him alive on Oct 16, 1927, and that death occurred, on the date stated above, at 10-20 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
119B
107A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Gastro Enteritis
(duration) ..... yrs. ..... mos. ..... ds.

118B

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH?
0 DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Roger W. Kennedy, M. D
10-16, 1927 (Address) Marshall Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Ridge Park Cem. — DATE OF BURIAL: Oct. 18 1927

20. UNDERTAKER: R. W. Campbell — ADDRESS: Marshall Mo.

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.