

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis* (No. *St. Louis Hospital #2*)

Registration District No. *791*
Final Registration District No. *1003*

File No. *11378*
Registered No. *3218*
St. Ward)

2. FULL NAME

Lander, Haynes
(a) Residence. No. *1636 Carroll* St., *95* Ward.

Length of residence in city or town where death occurred *7* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *Col.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ___ hrs. or ___ min.
<i>abt. 40</i>	<i>?</i>	<i>?</i>	<i>?</i>	

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER *Matt Haynes*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Anna F Woodard*
(Address) *City Hospital #2*

15. FILED *May 19 1928*
Max C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar 19, 1928*

17. I HEREBY CERTIFY That I attended deceased from *1/12* 19*28* to *3/19* 19*28*
that I last saw him... alive on *3/19* 19*28*, and that death occurred, on the date stated above, at *12:30 P.M.*

THE CAUSE OF DEATH WAS AS FOLLOWS:
Pulmonary T. B.
23A

CONTRIBUTORY (SECONDARY) *None*
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *Not known*
IF NOT AT PLACE OF DEATH... *no*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

19. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical*
(Signed) *Leo Boulet*
, 19 (Address) *City Hosp. #2*

*State the DISEASE CAUSING DEATH, or 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 *Washington Park* DATE OF BURIAL *Mar 23-1928*

20. UNDERTAKER *W. S. Wade* ADDRESS *4202 Jimmy*

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.

WRITE IN INK, WITH UNFADING INK—THIS IS A PERMANENT RECORD

