

1928

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

Do not use this space.

12931

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
Township _____ Primary Registration District No. 1991 Registered No. _____
City Springfield (Ne Springfield Baptist Hospital Ward _____)

2. FULL NAME

(a) Residence. No. 2005 N. Weller Ave. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 12 19 28

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

17. I HEREBY CERTIFY That I attended deceased from April 4, 19 28, to April 12, 19 28 that I last saw him alive on April 12, 19 28, and that death occurred, on the date stated above, at 3:20 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 5 - 1873

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 54 | 8 | 7 | _____

Subdural Hemorrhage and Hemorrhage in pons.

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

1860
1940
8:30 A (duration) _____ yrs. _____ mos. _____ ds.
Fracture
CONTRIBUTORY (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED

10. NAME OF FATHER Geo Hayden

{ IF NOT AT PLACE OF DEATH: _____

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

{ DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

12. MAIDEN NAME OF MOTHER Unknown

WAS THERE AN AUTOPSY: _____

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

WHAT TEST CONFIRMED DIAGNOSIS: _____

14. INFORMANT (Address) Mrs Dessie Hayden Springfield, Mo.

(Signed) C. P. Feller, M. D.

15. FILED H-14 '28 Cl. Host REGISTRAR

4-13, 19 28 (Address) Springfield 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 DATE OF BURIAL Delview Cemetery April 14 19 28

20. UNDERTAKER (ADDRESS) W. Plunged 40424 6th St. Springfield, Mo.

CAUSE OF DEATH in plain terms, so that at least a lay person can understand.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Greene
Township.....
City..... Springfield (No.....)

Registration District No. 318
Primary Registration District No. 2001

File No.....
Registered No. 284
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

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 17 19 28

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

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

Subdural hemorrhage and hemorrhage in pons fell in ice, Springfield Mo. Steep cuts No auto visible around

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

CONTRIBUTORY Traumatism
(SECONDARY) (duration) yrs. mos. ds.

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

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

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH? DATE OF

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

18. WAS THERE AN AUTOPSY?

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS?

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

(Signed)....., M. D. , 19 (Address)

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19

15. FILED 4-14-28 Oct first mo REGISTRAR

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1-1-28, so that it may be properly examined.

S-12951