

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. _____

Township New Primary Registration District No. _____

City Kansas City (No. Old City Hosp) St. _____ Ward _____

File No. 23938

Registered No. 3065

2. FULL NAME Oscar Haynes

(a) Residence No. 1419 E. 12th 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 19, 1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
30 6 28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Porter

(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) Louisiana

10. NAME OF FATHER Abn Haynes

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

12. MAIDEN NAME OF MOTHER Nora Bryant

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

14. INFORMANT Abn Haynes (Address) 2101 E. 9th St.

15. FILED 7/18 28 M. M. Croome REGISTRAR Asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-17-28

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 _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Homicide Firearms

18. WHERE WAS DISEASE CONTRATED _____ (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTOR (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy (Signed) Deputy coroner H.P.D.

(Address) Deputy coroner

*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 Blue Ridge Lawn DATE OF BURIAL July 19, 1928

20. UNDERTAKER Adkins Bros ADDRESS 2127 Duac

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.

