

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

Do not use this space.  
*Cancelled*  
**6122**  
File No. ....  
Registered No. *119*  
St. .... Ward)

**1. PLACE OF DEATH**

County *Greene* Registration District No. *318*  
Township ..... Primary Registration District No. *2001*  
City *Springfield* (No. *521 S. Kinbrough*)

**2. FULL NAME**

*Mrs. Martha Haines*  
(a) Residence, No. *521 S. Kinbrough* Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *W. H. Haines (dec)*

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

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

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Housewife*  
(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) *Ohio*

**10. NAME OF FATHER**

*Unknown Ben Hain*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) *England*

**12. MAIDEN NAME OF MOTHER**

*Unknown*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) *Unknown*

**14.**

INFORMANT *Mrs Anna English*  
(Address) *Springfield Mo*

**15.**

FILED *26 29* 19 *Ob. Forest Mo* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**2**  
16. DATE OF DEATH (MONTH, DAY AND YEAR) *2-4 1929*

17. I HEREBY CERTIFY, That I attended deceased from *1-16*, 19*29*, to *2-4*, 19*29* that I last saw *a* alive on *2-3*, 19*29*, and that death occurred, on the date stated above, at *6:45 a.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Permeous Anemia*

CONTRIBUTORY (SECONDARY) *Symptoms* (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? *No* DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? *Clotted*  
(Signed) *M. D. Sibley* M. D.  
, 19 (Address) *401 St Louis 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 *Green Lawn* DATE OF BURIAL *2/5 1929*

20. UNDERTAKER *Anna Whitney 534 St Louis*  
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.

MAR 22 1929

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