

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

Do not use this space.

9225 *W*

1. PLACE OF DEATH

County Stone
Township Cass
City (No. _____) _____ St. _____ Ward _____

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. _____

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

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 3rd 1850

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
78 5 20

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Mr. Hiram

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

12. MAIDEN NAME OF MOTHER Elizabeth Logan

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

14. INFORMANT Roy Hayden
(Address) W. A. Mason

15. FILED 4-5 1929 W. A. Mason REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28th 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1928 to Feb 23 1929 that I last saw him alive on Feb 19 1929 and that death occurred, on the date stated above, at 3 05 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

In bereavement of lungs
3 11 A
23 1929
(duration) yrs. mos. ds.
CONTRIBUTORY Chas. Hayden
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

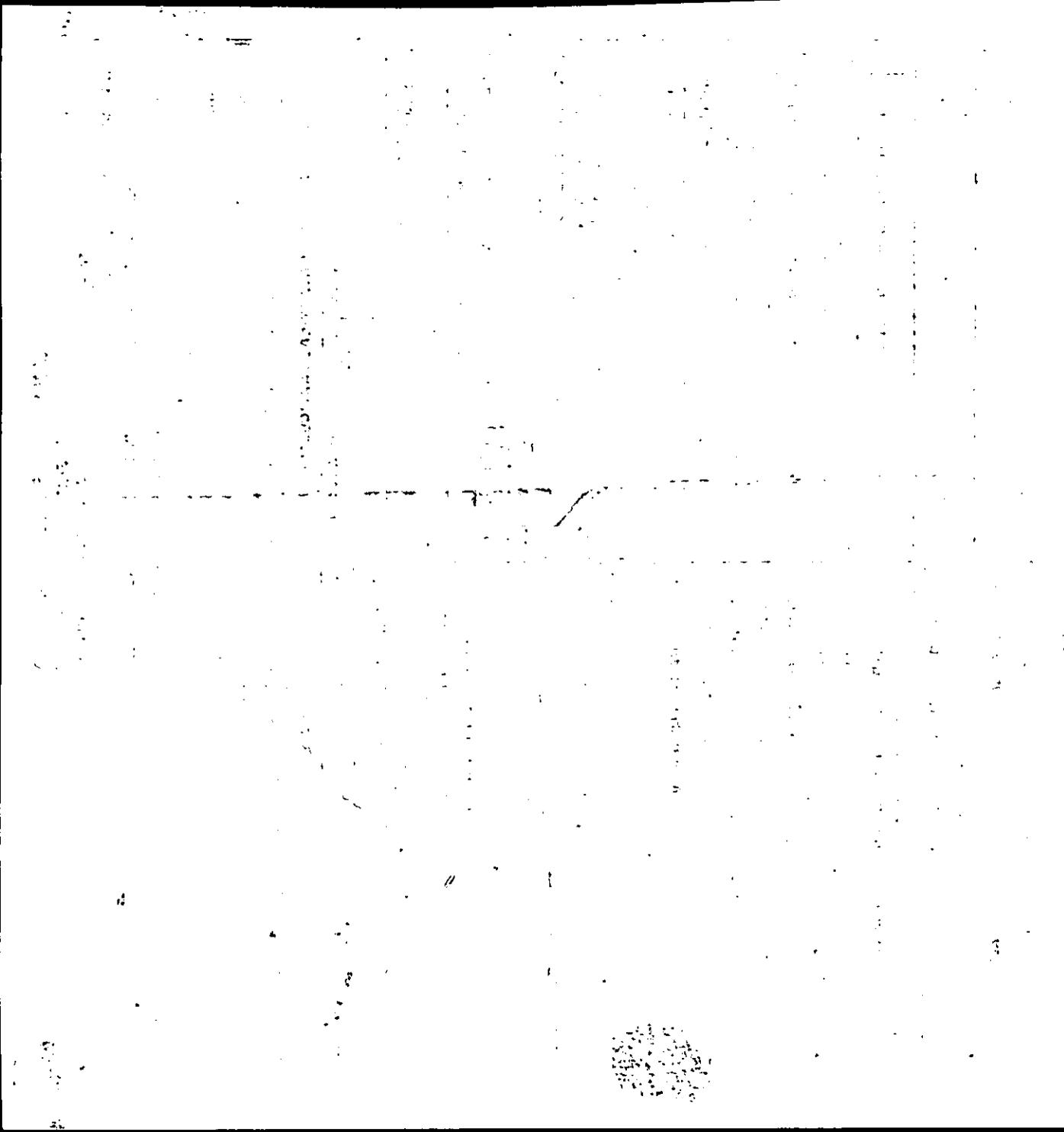
IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH. No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory
(Signed) W. B. Mason, M. D.

*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 Glenn Cemetery DATE OF BURIAL Feb 28 1929

20. UNDERTAKER G. B. Chaffin ADDRESS Osark Mo



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis
Township Cast
City (No.) (Ward)

Registration District No. 846
Primary Registration District No. 6111

File No. 9225
Registered No. 11

2. FULL NAME

Amanda Hayden

(a) Residence. No. St. Ward.
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 3 - 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 5 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Mr. Dixon

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

12. MAIDEN NAME OF MOTHER Elizabeth Logan

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

14. INFORMANT Roy Hayden
(Address) Nixa Mo.

15. FILED 4-5-29 H. A. Simon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 23 1929

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 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of Lungs

CONTRIBUTORY (SECONDARY) Influenza (duration) 6 or 8 yrs. mos. ds.
20 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Laboratory

(Signed) W. B. Wasson M. D.

, 19 (Address) Nixa 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

Glenn Cemetery Feb 24 1929

20. UNDERTAKER ADDRESS

W. B. Chaffin Nixa Mo

N.B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-9225