

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

Do not use this space.

11223

1. PLACE OF DEATH

County Jasper
Township _____
City Webb City (No. _____)

Registration District No. 417
Primary Registration District No. 3021

File No. _____
Registered No. 34
St. _____ Ward)

2. FULL NAME

Edward W. Haysler
(a) Residence. No. 820 West 15th St 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 31 1886

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	42	7	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer for Pitt
(b) General nature of industry, business, or establishment in which employed (or employer) State Oil Co.
(c) Name of employer Joplin

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

10. NAME OF FATHER Fredrick Haysler

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

12. MAIDEN NAME OF MOTHER Peresa Craft

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

14. INFORMANT Mr. Theodosia Haysler
(Address) 820 W. 15th St

15. FILED 3/15 1929 R. M. Stormad
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 13 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 7, 1929, to March 13, 1929, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 6:40 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Abscess of Right Lung
(Streptococci et tubercular)
23A

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

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) George M. Cox M. D.

, 19 1929 (Address) Webb City 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

Mt. Hope Cem 3/15/1929

20. UNDERTAKER ADDRESS Steele Und Co. Webb City Mo

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 PLAINLY, WITH CAPITAL LETTERS

49
25
17
7

176
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