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

Do not use this space.

33495

1. PLACE OF DEATH

County Greene — Registration District No. 318 — File No.

Township — Primary Registration District No. 2001 — Registered No. 763

City Springfield (No. 622 W. Commercial St. Ward)

2. FULL NAME Carrie M. Hayes

(a) Residence. No. 622 W. Commercial 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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 24-1872

7. AGE: Years 57 | Months 1 | Days 28 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(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) N. Y.

PARENTS

10. NAME OF FATHER Collins Stiles
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) N. Y.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT James A. Hayes
(Address) Springfield Mo.

15. FILED 10 24, 1929 Lon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 22 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1929, to Oct 22, 1929 that I last saw her alive on Oct 22, 1929, and that death occurred, on the date stated above, at 3 20 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza 11A
105B

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) Acute Laryngitis

(duration) yrs. mos. 6 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? Clinical

(Signed) R. F. Freeman, M. D
10/22, 1929 (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: Green Lawn Cemetery — DATE OF BURIAL: Oct. 24 1929

20. UNDERTAKER: J. W. Klingner & Co. — ADDRESS: 424 E. Cook St Springfield Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.