

N. B.—Every item of information should be carefully supplied. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 30 1930

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

Do not use this space.
9539

1. PLACE OF DEATH
 County New Madrid Registration District No. 604 File No. 29
 Township 11 Primary Registration District No. 5802 Registered No. 1
 City St. Louis St. Ward

2. FULL NAME Albert Haynes
 (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 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 Mary Haynes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 4 1859

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
70 | 3 | 203 | | |

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 27 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-19-30, 1930, to 3-27-30, 1930, that I last saw him alive on 3-26, 1930, and that death occurred, on the date stated above, at 12:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia
1. 11
1-10-30 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. 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?
 (Signed) W. S. Dwyer, M. D.
 , 19 (Address) New Madrid

*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.

9. BIRTHPLACE (CITY OR TOWN) New Madrid (STATE OR COUNTRY) MO

10. NAME OF FATHER Albert Haynes

11. BIRTHPLACE OF FATHER (CITY OR TOWN) New Madrid (STATE OR COUNTRY) MO

12. MAIDEN NAME OF MOTHER Saithy

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

14. INFORMANT Mrs. Mary Haynes (Address) New Madrid

15. FILED 19 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Evergreen Cem. DATE OF BURIAL 3-28 1930

20. UNDERTAKER Richards and Co ADDRESS New Madrid

... 322 ...
... 1950 ...

... 1950 ...

... 1950 ...

... 1950 ...

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County New Madrid Registration District No. 604 File No.
 Township Primary Registration District No. 5802 Registered No.
 City (No.) St. Ward

2. FULL NAME Albert Haynes
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

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

8. OCCUPATION OF DECEASED

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

(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 4/3/30 W. W. Samson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/27 19 30

17. I HEREBY CERTIFY That I attended deceased from 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:

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH..... DID AN OPERATION PRECEDE DEATH..... DATE OF..... WAS THERE AN AUTOPSY?..... WHAT TEST CONFIRMED DIAGNOSIS?..... (Signed)....., M. D. , 19 (Address)

*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 19
 20. UNDERTAKER ADDRESS

N. E. Item of information should be carefully supplied. A.C.P. should be stated EXACTLY. PHYSICIANS' DEATH in plain terms, so that may be properly classified. Exact statement of OCCUPATION is ver. R. I. TRAPS SHALL NOT RECEIVE A FEE FOR CERTIFICATES-UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-9639