

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

Do not use this space.

**1. PLACE OF DEATH**

County Boyer  
Towship Scott  
City Boyer (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 820  
Primary Registration District No. 6069

File No. 43089  
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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**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 Minnie Hayercraft  
(or) WIFE OF \_\_\_\_\_

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

7/16/73

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

58

5

12

**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

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

Ky.

**10. NAME OF FATHER**

Chris. C. Hayercraft

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

(STATE OR COUNTRY)

Ky.

**12. MAIDEN NAME OF MOTHER**

Rebecca Castile

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

(STATE OR COUNTRY)

Ky.

**14.**

INFORMANT (Address)

Joe Hayercraft  
1932

**15.**

FILED

19 32

E. Sheehan  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

12/29 1931

17. I HEREBY CERTIFY, That I attended deceased from 12/12, 1931, to 12/29, 1931 that I had saw him alive on 12/29, 1931, and that death occurred, on the date stated above, at 11 a m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Gastric Carcinoma

W.H.B.

**CONTRIBUTORY (SECONDARY)**

**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) J. H. Clinton, M. D.

19 (Address) Cross 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**

Northway Cemetery

12/30 1931

**20. UNDERTAKER**

**ADDRESS**

COM. G. (Town) Northway 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 UNFADING INK—THIS IS A PERMANENT RECORD

