

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

Do not use this space.

323

File No. ....

Registered No. 3

**1. PLACE OF DEATH**

County Butler Registration District No. 87  
Township Paplar Bluff Primary Registration District No. 3007  
City Paplar Bluff (No. ....) St. .... Ward)

**2. FULL NAME**

(a) Residence, No. Susie Alma Haynes St. Paplar Bluff Mo 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 Charles P. Haynes

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 17-1903

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>31</u>	<u>2</u>	<u>15</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saline Co Mo

13. NAME James Boyarth

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saline Co. Mo

15. MAIDEN NAME Florence Pemberton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Williamson Co Mo

17. INFORMANT Chas P. Haynes (ADDRESS) Paplar Bluff Mo R 1

18. BURIAL, CREMATION, OR REMOVAL PLACE Sparkman Cem DATE Jan 4 1934

19. UNDERTAKER (ADDRESS) Dr. P. Phelphs  
Paplar Bluff Mo

FILED 1-5-34 W. B. Wiley Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 2 1934

22. I HEREBY CERTIFY, that I attended deceased from Dec 20 - 1933 to Jan 2nd 1934

I last saw her alive on Jan 2 1934 Death is said

to have occurred on the date stated above, at 3 P. m.

The principal cause of death and related causes of importance were as follows:

Myocarditis  
12-25-33

Other contributory causes of importance:

Pelvic Peritonitis  
Following Salpingitis

Name of operation Salpingectomy Date Dec 25-33

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

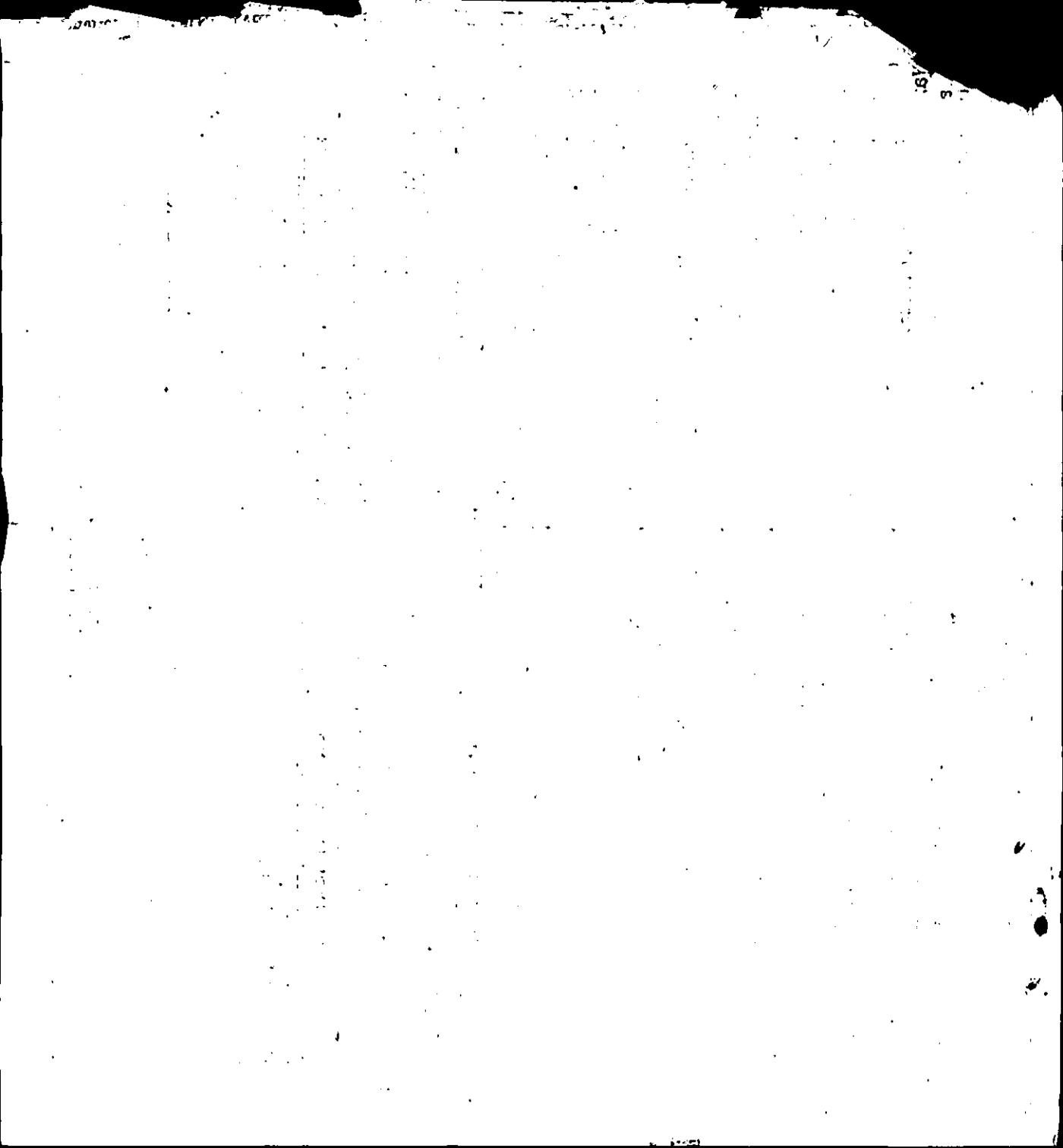
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

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

(Address) Paplar Bluff Mo



*Butler*

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Dessie Alma Haynes*  
Who died at \_\_\_\_\_ on *Jan 2 - 1934*  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex *F* Color or race *W* Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years *31* Months *2* Days *15*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: *myocarditis*

Other contributory causes of importance *Polioe peritonitis following salpingitis*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

*Staphylococcus* *No injury, not perusal*

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify *Doctor says that it was probably from gonorrhoeal infection*

Name of physician *Dr. W. K. Brandon*

Address of physician *Poplar Bluff Mo*

Signature of Registrar *W. S. Bailey*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,  
*E. T. McLaughlin M.D.*

Reg. Dist. No. 89

Primary Reg. Dist. No. 3007

Special Agent.

