

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

Do not use this space.

28992

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. R#4)

Registration District No. 318
Primary Registration District No. 5439
(Co. J. B. Sanitarium)

File No. 424
Registered No. St. Ward

2. FULL NAME

(a) Residence, No. 416 E. Atlantic St. Springfield, Mo.

(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) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 20-1911

7. AGE YEARS 23 MONTHS 1 DAYS 29 If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Plumber Helper
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Construction Work
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) Mo.

FATHER
13. NAME Ben E. Highfill

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

MOTHER
15. MAIDEN NAME Mal Lane

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

17. INFORMANT (ADDRESS) Mrs. Marjorie Lyndell Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn Cemetery DATE Aug 21, 1934

19. UNDERTAKER (ADDRESS) John W. Simpson & Co., Springfield, Mo.

20. FILED 8-21-34 1934 John W. Simpson Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 19, 1934

22. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1934, to Aug 19, 1934. I last saw him alive on Aug 15, 1934 Death is said to have occurred on the date stated above, at 4:20 a.m.

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

Myocardial failure - acute
Abcess of the lung, left
Date of onset
Name of operation no Date of
What test confirmed diagnosis? X-ray Was there an autopsy? no

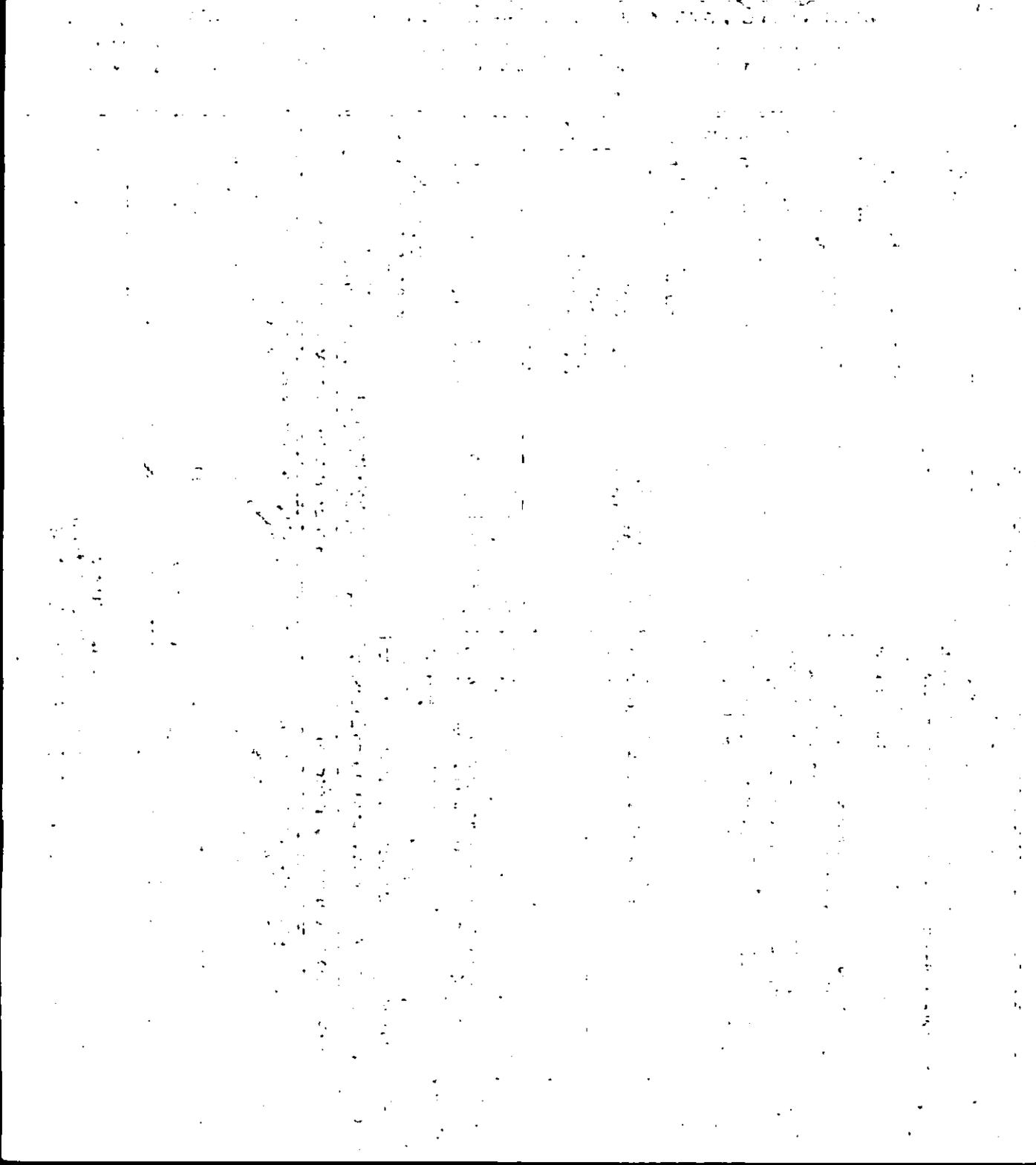
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury....., 19..... Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury..... Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no If so, specify (Signed) John W. Simpson, M. D. (Address) Springfield

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.



WASHINGTON

Dear Sir:

Greene Springfield

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: Bernard Haysfield
Who died at _____ on Aug 19-1934
Residence: No. _____ St. _____
(If nonresident, (city or town))

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 23 Months 1 Days 29

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.

Myocardial failure - acute
Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) Adverse of left lung
Birthplace of father (State or country) _____
Birthplace of mother (State or country) Probably the - No laboratory exam of
Principal cause of death: Sputum was made

Other contributory causes of importance 23
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.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____
Signature of Registrar [Signature] Date filed 10/12/34

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.

Reg. Dist. No. 318

Very truly yours,
E. T. McLaugh M.D.
gc

Primary Reg. Dist. No. 5439

Special Agent.

