

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.

APR 17 1939

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

9788  
Do not use this space.

1. PLACE OF DEATH <sup>2</sup>  
 (a) County Jackson Registration District No. 399  
 (b) Township New Primary Registration District No. 100 Registered No. 1394  
 (c) City Manass City (d) Street No. 1614 Summit St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Henry Hayslip  
 (a) Residence, No. 1614 Summit  (If nonresident, give city or town and State)

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 Martha Hayslip

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 31 - 1869

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>69</u>	<u>6</u>	<u>39</u>	

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

9. Industry or business in which work was done, as saw mill, bank, etc. 6 yrs -

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) Missouri

13. NAME John H. Hayslip

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

15. MAIDEN NAME No record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No record

17. INFORMANT (ADDRESS) Martha Hayslip 1614 Summit

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE April 14 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mr. C. R. Foster 918 - Brooklyn N. C. Mo.

20. FILED Apr 1 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 30 1939

22. I HEREBY CERTIFY, That I attended deceased from 3-9-1939 to 3-30-1939  
 I last saw him alive on 3-30-1939. Death is said to have occurred on the date stated above, at 4:40 pm.  
 The principal cause of death and related causes of importance were as follows:  
Bronchial asthma  
9/10  
 Other contributory causes of importance:  
Acute Endocarditis

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... 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) C. C. Duhon  
 (Address) 2 East 39th St. Room 204 Hyde Park Bldg. Kansas City, Mo.

Date of onset 1937

Dr. Mabry

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, \_\_\_\_\_

\_\_\_\_\_ or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed Charley Wise

Licensed Embalmer No. 2570

P. O. Address 918 Brooklyn

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**