

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

41085
Do not use this space.

1. PLACE OF DEATH

(a) County Washington ³ Registration District No. 887
 (b) Township Genoa ¹ Primary Registration District No. 189 Registered No. _____
 (c) City _____ (d) Street No. _____ 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

400 Island, Haley
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 27 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
44 1 10

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. min
 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) Fremont Mo

FATHER 13. NAME Fred Haley 0
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky 1

MOTHER 15. MAIDEN NAME Sarah Gregory 0
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fremont Mo

17. INFORMANT (ADDRESS) ella wideman

18. BURIAL, CREMATION, OR REMOVAL PLACE Desoto Mo DATE May 8 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Sparks Peter

20. FILED Oct 27 1939 G.F. Currence 808
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6 1939

22. I HEREBY CERTIFY, That I attended deceased from no physician to _____, 19____.

I last saw h_____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 5:30 p.m.

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

Fracture of skull
fracture of neck
 Date of onset _____

Other contributory causes of importance:
(accidental death)
(Verdict of Coroner jury)

Name of operation _____ Date of _____
 What test confirmed diagnosis? examined Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? accident Date of injury 5-6-39
 Where did injury occur? Blm, Mo, Washington Ca.
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.
public place - Hwy. B.
 Manner of injury truck turned over on head
 Nature of injury fracture of neck & skull

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____ (Signed) Joseph L. Thurman Coroner, M. D.
 (Address) Peters, 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.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.