

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

Do not use this space.

FILED FEB 13 1940

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township

Primary Registration District No. 2901

City Springfield

(No. Burge Hospital)

File No. 2382

Registered No. 43

St. _____ Ward _____

2. FULL NAME

Joe Russell Haynie, Jr.

(a) Residence, No. Basin St. Ave, Mo. Ward _____

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. (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) Infant

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 11, 1940

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 7 0 0 4

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

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) Springfield Mo.

13. NAME Joe R. Haynie

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

15. MAIDEN NAME Margaret L. Root

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

17. INFORMANT (ADDRESS) Joe R. Haynie Basin St. Ave Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Yeakley Chapel Cemetery 1-16 40

19. UNDERTAKER (ADDRESS) Olma Schreyer Springfield, Mo.

20. FILED 1/15 1940 Chas. A. George, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-15-1940

22. I HEREBY CERTIFY, That I attended deceased from 1-13, 1940, to 1-15-40, 1940.

I last saw h. _____ alive on 1-14-40, 19____. Death is said

to have occurred on the date stated above, at 8 A. m.

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

Date of onset

Congenital malformation of chest
" " " " " "
" " " " " "
" " " " " "

Other contributory causes of importance:

157 C

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? _____

If so, specify _____

(Signed) Urban J. Prusicki, M. D.

(Address) Springfield, 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.

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