

MAY 13 1940 908

State File No. _____

Registration District No. _____

Primary Registration District No. 4549

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Wright
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) _____
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME JAMES HARRY HAINING
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased. Jan 9 - 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months 3 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace Wright B Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

MOTHER FATHER
11. Industry or business _____
12. Name George Haining
13. Birthplace Jack
(City, town, or county) (State or foreign country)
14. Maiden name Pracht James Gaffney
15. Birthplace Wright
(City, town, or county) (State or foreign country)

16. (a) Informant George Haining
(b) Address Wright

17. (a) Jelly Bennett (b) Date thereof 4 - 21 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jelly Bennett

18. (a) Signature of funeral director George Haining
(b) Address Wright

19. (a) 4-21-40 (b) Bernice M. Haining
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright
(c) City or town Wright (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 20
year 1940 hour 12 minute 35 M.

21. I hereby certify that I attended the deceased from 4-14-40
4-20 1940, to 4-20 1940;
that I last saw him alive on 4-19 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

Signature J. W. Haining (M. D. or other) _____

Address Wright Date signed 4-20-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6,

District File Number 540 1271

Date Filed MAY 9 1940

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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.

No. 213
2-21-40
X222

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16422

Registration District No. 908

Primary Registration District No. 4549

Registrar's No. 23

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Wright

(b) City or town Monroe
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME James Harry Haring

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>3</u>	<u>13</u>		hr. min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month 4 day 20
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia

Due to no complications

Due to influenza

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____
(Specify type of place) (e) Means of injury

23. Signature R. W. Dewey _____
(M.D. or other)

Address Monroe _____ Date signed _____

SUPPLEMENTAL

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

