

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **25560**  
Registrar's No. **34**

Registration District No. **460**

Primary Registration District No. **4274**

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

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Higginsville, Mo.  
(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 Murray G. Haynes **520**

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Florence Haynes 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct 3rd 1865  
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 17 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business /

MOTHER FATHER { 12. Name Frank Haynes  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Julia Haynes  
15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Florence Haynes

(b) Address Higginsville, Mo.

17. (a) Burial (b) Date thereof 7/23/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville Colored Cemetery

18. (a) Signature of funeral director A. Wood  
(b) Address Higginsville, Mo.

19. (a) 7-27-40 (b) Tripping Webb  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Solayado  
(c) City or town Higginsville  
(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 20 day July year hour minute 12 M.

21. I hereby certify that I attended the deceased from June 2, 1940 to July 20, 1940  
that I last saw him alive on July 20, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive cardiac vascular disease Duration 5yr

Due to Bronchial pneumonia

Other conditions (Include pregnancy within 3 months of death) 45yr

Major findings: Of operations  
Of autopsy

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?

413  
While at work? (Specify type of place) (e) Means of injury

23. Signature A. Russell (M. D. or other)  
Address Higginsville Date signed July 30

RECEIVED  
District Health Officer No. B  
District File Number  
Date Filed 2-5-40

**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 *Robert R. [Signature]*  
Licensed Embalmer No. 3637  
P. O. Address Higginsville, Mo

**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.**