

FILED SEP 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29361

Registration District No. 678

Primary Registration District No. 5904

Registrar's No.

1. PLACE OF DEATH:

(a) County Phelps
(b) ~~City or town~~ Rural, St James Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2

(If not in hospital or institution, write street number or location)

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

In this community Two months
years, months or days)3. (a) PRINT FULL NAME David L. Haynes 370

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive deceased years7. Birth date of deceased October 9 1854
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
85 8 24 hr. min.9. Birthplace Bland Mo
(City, town, or county) (State or foreign country)10. Usual occupation Farmer (retired)

11. Industry or business _____

12. Name William Haynes13. Birthplace unknown
(City, town, or county) (State or foreign country)14. Maiden name Rebecca Shockley15. Birthplace unknown
(City, town, or county) (State or foreign country)16. (a) Informant Mrs Mary L. Swan(b) Address St James, Mo17. (a) ~~Place of burial~~ (b) Date thereof July 6, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Halliday Cem18. (a) Signature of funeral director W. L. Stickleler(b) Address Belle, Mo19. (a) 1 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps(c) City or town Rural, St James Twp
(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 July day 3rd
year 1940 hour 8 minute 30 P.M.21. I hereby certify that I attended the deceased from May, 1940, to July 3, 1940
that I last saw him alive on July 3, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Valvular heart disease
Due to Aortic stenosis 1937

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

Of autopsy _____

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? _____

6!!!
While at work? _____ (Specify type of place) (e) Means of injury _____23. Signature William Stickleler (M. D. or other) 1Address St James Mo Date signed 7-4-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number. 840862

Date Filed _____

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 O. E. Licklider

Licensed Embalmer No. 3544

P. O. Address H. P. Geim

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29361**

Registration District No. **678**

Primary Registration District No. **2904**

Registrar's No. _____

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

1. PLACE OF DEATH
 (a) County **St. Charles**
 (b) City or town **James T. P.**
(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 **David L. Hayma**
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 **wid**
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 **85** Months **8** Days **24**
 If less than one day _____ 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. (c) _____ **(b) Date thereof.** (Month) (Day) (Year)

(c) Place: burial or cremation. _____

18. (a) Signature of funeral director. _____

(b) Address. _____

19. (a) **10-18-40** **(b)** **Elsie B. Houch**
(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.

MEDICAL CERTIFICATION
20. DATE OF DEATH. Month **July** day **3**
 year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 and that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

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

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____

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

23. Signature **H. H. Bremer** (M. D. or other) _____
James _____
 Address _____
 _____ signed

Duration

 Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

