

State File No. \_\_\_\_\_

FILED FEB 24 1944  
 Registration District No. 170

Primary Registration District No. 3033

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:  
 (a) County LACLEDE  
 (b) City or town LEBANON  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
303 EAST COMMERCIAL  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)  
 In this community 30 yrs.

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County LACLEDE  
 (c) City or town LEBANON  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 303 EAST COMMERCIAL  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Thos. H. HAYNES  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month JAN day 16th  
 year 1944 hour 9 minute 30 A. M.  
 21. I hereby certify that I attended the deceased from Jan. 13, 1944  
 \_\_\_\_\_, 19\_\_\_\_, to Jan. 16, 1944  
 that I last saw him alive on Jan. 15, 1944  
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or Race W  
 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife Dolly BREADON  
 6. (c) Age of husband or wife if alive 70 years  
 7. Birth date of deceased JUNE 1 1972  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration 3 days

8. AGE: Years 71 Months 7 Days 15  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions 8301  
(Include pregnancy within 3 months of death)

9. Birthplace Polaska Co MO  
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business \_\_\_\_\_

12. Name DAVID HAYNES

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

14. Maiden name SIS. CARPENTER

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

16. (a) Informant Mrs. T. H. Haynes

(b) Address LEBANON MO

17. (a) BURIAL (b) Date thereof 1-18-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEBANON MO

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) 1-31-44 (b) Grace Roper  
(Date received local registrar) (Registrar's signature)

PHYSICIAN  
 Underline the cause to which death should be charged statistically.  
 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?  
 \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury 0  
 23. Signature H. A. Hamilton (M. D. or other) \_\_\_\_\_  
 Address Lebanon, Mo. Date signed 1/16/44

1090

Received

Laclede County Health Unit

File No.

1-44-7

Date Filed

2/21/44

---

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. 1161

P. O. Address. Lebanon 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, fact should be so stated above.**