

No. 2  
5-43  
5-17-39  
X36671

FILED JUN 12 1944  
Registration District No. 2

Primary Registration District No. 3127

Registrar's No. 41

1. PLACE OF DEATH:

(a) County Jasper

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

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

(d) Length of stay: In hospital or institution 6 1/2 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. 311 South Hall Street  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Henry R. Haines

3. (b) If veteran, name war no data

3. (c) Social Security No. 110118

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8  
year 1944 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from May 6, 1944, to May 8, 1944  
that I last saw him alive on May 18, 1944  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Eula Haines

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: July 27, 1882  
(Month) (Day) (Year)

Immediate cause of death Asthma

Due to	Duration

8. AGE: Years 61 Months 9 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

9. Birthplace Jasper County Missouri  
(City, town, or county) (State or foreign country)?

10. Usual occupation Unemployed

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

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

12. Name John Haines

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

14. Maiden name Emma Cunningham

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

16. (a) Informant Widow: Eula Haines

(b) Address Webb City, Missouri

17. (a) burial (b) Date thereof 5/11/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oronogo Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Hedge-Nelson

(b) Address Webb City, Mo.

19. (a) May 11, 1944 (b) Mrs. Lillie Hagle  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Means of injury)

23. Signature G. W. Cox (M.D. or other) Dr.  
Address Webb City, Mo. Date signed 5-10-44

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

MOTHER FATHER

1180

44-5-463

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..... *E. O. Hedge* .....

Licensed Embalmer No. *2859* .....

P. O. Address *Webb City, 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.

Registration District No. 155

Primary Registration District No. 3127

Registrar's No. 41

1. PLACE OF DEATH

(a) County Jasper

(b) City or town Webb City  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(b) County \_\_\_\_\_

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Henry R. Haines

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I met him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death asthma

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 27 1889  
(Month) (Day) (Year)

8. AGE: Years 61 Months 9 Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions subjection of lungs  
(Include pregnancy within 5 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 13 pl

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? \_\_\_\_\_

23. Signature G. W. Cox (M. D. or other) D.O.  
Address Webb City, Mo. Date signed 6-14-44

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

MOTHER FATHER

SUPPLEMENTARY

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

18338