

No. 2-12-45-17-39 X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4136

State File No.

Registrar's No.

FILED MAR 14 1947

Registration District No.

Primary Registration District No.

4059

86

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Gardiner  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 3 weeks years; months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Clay 999  
(c) City or town Piggott 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 2  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM HENRY HAYWOOD

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 30

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 20 1878 (Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farming

11. Industry or business.

12. Name Allen Haywood  
13. Birthplace Tenn. (City, town, or county) (State or foreign country)  
14. Maiden name Taylor  
15. Birthplace Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant Henry Haywood  
(b) Address Piggott Ark.

17. (a) Burial (b) Date thereof Feb 28 1947 (Month) (Day) (Year)  
(c) Place: burial or cremation Carpenter's Chapel

18. (a) Signature of funeral director O. J. Mowery  
(b) Address Piggott Ark.

19. (a) 3-4-47 (b) R. S. Minette (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 26 day February, 1947  
year 8 hour 45 minute P.M.

21. I hereby certify that I attended the deceased from 23 January 1947 to 3 February 1947  
that I last saw him alive on 3 February 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure  
Due to Tuberculosis

Due to \_\_\_\_\_  
Other conditions 13B  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (c) Cause of injury \_\_\_\_\_  
23. Signature W. E. Turner (M.D. or other)  
Address Piggott Ark. Date signed 27 Feb 47

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

MOTHER FATHER

35

RECEIVED  
District Health Office No. 2  
District # 347-306  
Date 3-12-41

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 John R. Casner  
Licensed Embalmer No. 2912  
P. O. Address Rectw, Ark

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. *8 March*Registration District No. *43*Primary Registration District No. *4059*Registrar's No. *86*

## 1. PLACE OF DEATH:

- (a) County *Butler*  
 (b) City or town *Orlin*  
 (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  
 years, months or days)

3. (a) PRINT  
FULL NAME*Wm H. Haywood*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.....7. Birth date of deceased *Dec 20*  
(Month) (Day) (Year)

## 8. AGE:

Years *76* Months Days  
If less than one day  
hr. min.9. Birthplace  
(City, town, or county) *Sen*  
(State or foreign country)

## 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)

## 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) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Feb* Year *1947* hour *2 1/2* minute *.....* M.21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.Duration  
Immediate cause of death.....Due to *Pulmonary and  
Laryngeal etc*

Due to.....

Other conditions.  
(Includes pregnancy within 3 months of death)Major findings:  
Of operations.....

Of autopsy.....

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged statisti-  
cally.

## 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)  
Means of injury.....23. Signature *Walter E. Turner* (M. D. or other)  
Address *1199 St. 1st* Date signed *15 March 1947*

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

SUPPLEMENTARY

S-4136