

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33158

State File No. ....

FILED OCT 21 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 977

|                                                                                                                                           |  |                                                                                                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BUTLER</u>                                                                                              |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo.</u> b. COUNTY <u>BUTLER</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>POPLAR BLUFF</u>                                          |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>POPLAR BLUFF</u>                                      |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>POPLAR BLUFF HOSPITAL</u> |  | d. STREET ADDRESS (If rural, give location) <u>1106 MARY ST</u>                                                                       |  |

|                                        |                          |                            |                         |                                                               |
|----------------------------------------|--------------------------|----------------------------|-------------------------|---------------------------------------------------------------|
| 3. NAME OF DECEASED<br>(Type or Print) | a. (First) <u>FINN'S</u> | b. (Middle) <u>ALLISON</u> | c. (Last) <u>HAYNES</u> | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>OCT 4 1949</u> |
|----------------------------------------|--------------------------|----------------------------|-------------------------|---------------------------------------------------------------|

|                       |                                  |                                                                          |                                           |                                                                                                         |
|-----------------------|----------------------------------|--------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------|
| 5. SEX<br><u>MALE</u> | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>MARRIED</u> | 8. DATE OF BIRTH<br><u>JULY 13 - 1866</u> | 9. AGE (In years last birthday) <u>83</u><br>IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min. |
|-----------------------|----------------------------------|--------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------|

|                                                                                                                         |                                               |                                                                     |                                           |
|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------|-------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED CARPENTER</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>-</u> | 11. BIRTHPLACE (State or foreign country)<br><u>Clonesport 1 KY</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>US</u> |
|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------|-------------------------------------------|

|                                                |                                                     |                                                     |
|------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|
| 13a. FATHER'S NAME<br><u>DR CHARLES HAYNES</u> | 13b. MOTHER'S MAIDEN NAME<br><u>ELIZA JANE TATE</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Jessie HAYNES</u> |
|------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|

|                                                                                                                       |                                     |                                                                               |                                   |
|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------|-----------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u> | 16. SOCIAL SECURITY NO.<br><u>-</u> | 17. INFORMANT'S SIGNATURE OR NAME<br><u>Mrs Jessie Haynes Poplar Bluff Mo</u> | ADDRESS<br><u>Poplar Bluff Mo</u> |
|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------|-----------------------------------|

|                                                                                                                                                                                                                               |                                                                                                                                                                                                         |  |                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia -</u>                                                                                                                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks</u><br><br><u>2 years</u><br><br><u>6 mo</u> |
|                                                                                                                                                                                                                               | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Prostatic urinary</u><br><u>Obstruction.</u><br>DUE TO (c) _____ |  |                                                                                           |
|                                                                                                                                                                                                                               | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                                                                     |  |                                                                                           |

|                        |                                  |                                                                                     |
|------------------------|----------------------------------|-------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|-------------------------------------------------------------------------------------|

|                                          |                                                                                          |                                                 |
|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|

|                                                                            |                                                                                                        |                            |
|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><u>10:30 AM 10/4/49</u> | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------|

22. I hereby certify that I attended the deceased from 1 Oct 1949 to 4 Oct 1949, that I last saw the deceased alive on 3 Oct 1949, and that death occurred at 3:58 A.M., from the causes and on the date stated above.

|                                      |                   |                                                |                                     |
|--------------------------------------|-------------------|------------------------------------------------|-------------------------------------|
| 23a. SIGNATURE<br><u>Brookins MD</u> | (Degree or title) | 23b. ADDRESS<br><u>321 Oak Poplar Bluff Mo</u> | 23c. DATE SIGNED<br><u>7 Oct 49</u> |
|--------------------------------------|-------------------|------------------------------------------------|-------------------------------------|

|                                                            |                                  |                                                           |                                                                                  |
|------------------------------------------------------------|----------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> | 24b. DATE<br><u>Oct 9 - 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY<br><u>SPARKMAN Cem</u> | 24d. LOCATION (City, town, or county) (State)<br><u>10 mi W. POPLAR BLUFF Mo</u> |
|------------------------------------------------------------|----------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------|

|                                                  |                                                |     |                                                         |                                   |
|--------------------------------------------------|------------------------------------------------|-----|---------------------------------------------------------|-----------------------------------|
| DATE REC'D BY LOCAL REG.<br><u>Oct 12 - 1949</u> | REGISTRAR'S SIGNATURE<br><u>Wm. H. Johnson</u> | 428 | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>W. T. Phelps</u> | ADDRESS<br><u>Poplar Bluff Mo</u> |
|--------------------------------------------------|------------------------------------------------|-----|---------------------------------------------------------|-----------------------------------|

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

12  
7  
3

OCT 17 REC'D

1049-321

BUTLER COUNTY HEALTH CENTER  
POPLAR BLUFF, MISSOURI

MAR 19 1956

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *V. J. Phelps*

Licensed Embalmer No. *3231*

P. O. Address *Poplar Bluff 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.