

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS JUL 1 1960

85-60-022246  
STATE FILE NUMBER

Registration District No. 13 Primary Registration District No. 5059 Registrar's No. 85

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Barry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Barry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Ozark Township</b>		Length of stay in 1b <b>Years</b>	c. CITY OR TOWN <b>Aurora Star Route</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Aurora Star Route</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>BERTEN</b> Last <b>HAYNES</b>			4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1960</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/18/87</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (City and state or country) <b>Barry Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>William Haynes</b>	13b. MOTHER'S MAIDEN NAME <b>Alice Bell</b>	14. NAME OF HUSBAND OR WIFE <b>Nancy Haynes</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Nancy Haynes; Aurora, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Histoplasmosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <b>12:10</b> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	Month <b>6</b> Day <b>22</b> Year <b>1960</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Aurora</b>	COUNTY <b>Barry</b>	STATE <b>Mo.</b>
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21. I attended the deceased from **6/11/60** to **6/22/60** and last saw **him** live on **6/21/60**  
Death occurred at **12:10 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title) <b>med</b>	22b. ADDRESS <b>Aurora</b>	22c. DATE SIGNED <b>6/23/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/24/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Manle Park</b>	23d. LOCATION (City, town, or county) <b>Aurora, Mo.</b>
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24. FUNERAL DIRECTOR <b>Arnold's Funeral Home; Aurora, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>6-23-60</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed G. R. Arnold

Licensed Embalmer No. 4929

P. O. Address Aurora, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.