

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

10027

**1. PLACE OF DEATH**

County Pemissot

Township Hayth

City \_\_\_\_\_

Registration District No. 659

Primary Registration District No. 5864

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

Registered No. 38

St. \_\_\_\_\_

Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

Hayth Mo St.

Ward \_\_\_\_\_

(If nonresident give city or town and State)

How long in U.S., if of foreign birth?

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

F

4. COLOR OR RACE

W. pers.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

S.

5A. IF MARRIED, WIDOWED OR DIVORCED (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Sept 28 - 1922

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

5

6.

2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Gillett Ark

10. NAME OF FATHER

Will Sanders

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss.

12. MAIDEN NAME OF MOTHER

Laura Bristow

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ark.

14.

INFORMANT (Address)

Wm Sanders Hayth Mo

15.

FILED

3/31/28

J. P. Johnson  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR)

3 - 30 19 28

17.

I HEREBY CERTIFY That I attended deceased from 3-30 1928 newark Mo. to 3-31 1928 that I last saw alive on \_\_\_\_\_ 1928, and that death occurred, on the date stated above, at 6 P. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Bronchial Pneumonia

CONTRIBUTORY (SECONDARY)

aged

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH

WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

J. P. Johnson

M. D.

(Address)

Hayth Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURES OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

West. Cannon, Cal.

3/31/1928

20. UNDERTAKER

ADDRESS

Hugh Davis

Hayth, Mo



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**  
 County Demiseal Registration District No. 65-3 File No. \_\_\_\_\_  
 Township Hayti Primary Registration District No. 1-864 Registered No. 38  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward \_\_\_\_\_)

**2. FULL NAME** Hattie Sanders

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

**3. SEX** \_\_\_\_\_ **4. COLOR OR RACE** \_\_\_\_\_ **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) \_\_\_\_\_

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** \_\_\_\_\_

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** \_\_\_\_\_

<b>7. AGE</b>	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
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**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** \_\_\_\_\_

**10. NAME OF FATHER** \_\_\_\_\_

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** \_\_\_\_\_

**12. MAIDEN NAME OF MOTHER** \_\_\_\_\_

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** \_\_\_\_\_

**14. INFORMANT (Address)** \_\_\_\_\_

**15. FILED** 3/30/38 J.W. Johnson REGISTRAR

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 3-30-38

**17. I HEREBY CERTIFY**, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Bronchial Pneumonia  
 (duration) \_\_\_\_\_ yrs. mos. ds.  
**CONTRIBUTORY (SECONDARY)** Whooping Cough  
 (duration) \_\_\_\_\_ yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** \_\_\_\_\_ **DATE OF BURIAL** \_\_\_\_\_ 19\_\_\_\_

**20. UNDERTAKER** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-10027