

SEP 27 1938

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

Do not use this space.

1. PLACE OF DEATH *Jameson*

County.....

Registration District No. *574*

Township *Jameson*

Primary Registration District No. *4338*

City *245*

(No. *5772 A*)

File No. *29525*

Registered No. ....

St. ....

Ward) ....

2. FULL NAME *Blueson Oscar Hayes*

(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

*male*

4. COLOR OR RACE

*white*

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

*single*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-29-1938*

22. I HEREBY CERTIFY, That I attended deceased from

19 *Never* to 19 .....

I last saw him alive on .....

to have occurred on the date stated above, at .....

The principal cause of death and related causes of importance were as follows:

*Suicide*

Date of onset

*Sudden death*

Other contributory causes of importance: *167*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *1894-4-15*

7. AGE

YEARS

MONTHS

DAYS

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

*54*

*4*

*13/0*

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

*Farmer*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

*Jameson Mo*

FATHER

13. NAME

*Walter H. Hayes*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

*Germany*

MOTHER

15. MAIDEN NAME

*Pauline Wagner*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

*Germany*

17. INFORMANT (ADDRESS)

*Ed Miller*

18. BURIAL, CREMATION, OR REMOVAL

*Interment*

PLACE

*Jameson*

DATE

*30*

1938

19. UNDERTAKER (ADDRESS)

*Charley Hulbick*

20. FILED

*Reg 28*

*1938 Mrs. Abbie O'Neil*

Registrar.

Name of operation *None* Date of .....

What test confirmed diagnosis? *Clinical* Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? *Suicide* Date of injury *8-29-1938*

Where did injury occur? *his home* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *gun shot - wound*

Nature of injury *gunshot - in head*

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify

*H. P. Poberay* Coroner, M. D.

(Address) *California Mo*

*566*



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

295-20-  
Do not use this space.

1. PLACE OF DEATH

(a) County Moniteau Registration District No. 574  
 (b) Township Jenn Primary Registration District No. 5772A Registered No. \_\_\_\_\_  
 (c) City Jenn (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Alvan Oscar Heyssel

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S  
 (write the word)  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1884-4-15  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
54 4 14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Sept 2 1938 Miss Abbie O'Neal Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-29, 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
 I last saw h. alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_ (Signed) H. P. Dakey M. D.  
 (Address) California

SUPPLEMENTARY

STARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

