

1. PLACE OF DEATH a. COUNTY Dallas		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Texas b. COUNTY Dallas	
b. CITY OR TOWN (If outside city limits, give precinct no.) Dallas		c. LENGTH OF STAY in 1 b. 48 years	
d. NAME OF (if not in hospital, give street address) HOSPITAL OR INSTITUTION Baylor Hospital		d. STREET ADDRESS (If rural, give location) 606 Cristler	
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		e. IS RESIDENCE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (a) First James (b) Middle Clifton (c) Last Haislip			4. DATE OF DEATH January 26, 1970
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1891
9. AGE (in years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Minutes	IF UNDER 24 HRS. Hours Minutes
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Operator		10b. KIND OF BUSINESS OR INDUSTRY Dallas Transit Co.	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Pryor Haislip		14. MOTHER'S MAIDEN NAME Lelia Clifton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. 452-05-1177 A	
17. INFORMANT Alta Betty Haislip			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: TEXAS DEPARTMENT OF HEALTH FILED FEB 9 1970 BUREAU OF VITAL STATISTICS (a) Cerebrovascular thrombosis with paralysis on left 9 days (b) _____ (c) _____ DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
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.)	
20c. TIME OF INJURY Hour Month Day Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I hereby certify that I attended the deceased from 5-8-63 19____ to 1-26-70 19____ and last saw the deceased alive on 1-25-70 19____. Death occurred at 3 A. m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Channing Wootz M.D. (Degree or title)		22b. ADDRESS 4105 Live Oak	
22c. DATE SIGNED 1-27-70			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-27-70	
23c. NAME OF CEMETERY OR CREMATORY Grove Hill Cemetery			
23d. LOCATION (City, town, or county) (State) Dallas Texas		24. FUNERAL DIRECTOR'S SIGNATURE Dudley M. Hughes Funeral Home (Buckner)	
25a. REGISTRAR'S NO. 819		25b. DATE REC'D BY LOCAL REGISTRAR JAN 29 1970	
25c. REGISTRAR'S SIGNATURE Maurine Lamm			