31

MAY 24 1929

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

Do not use this space.

14273

1. PLACE OF DEATH
County Daviess Registration District No. 251
Township Grand Rivers Primary Registration District No. 5350
City ..... (No. ..... St. ..... Ward)

File No. .....
Registered No. .....

2. FULL NAME Thos. K. Hays
(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 59 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martha Ellen Hays

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 11-1845

7. AGE Years 83 Months 8 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) agriculture
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Daviess Co. Mo.

PARENTS
10. NAME OF FATHER Wm B. Hays
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know.
12. MAIDEN NAME OF MOTHER Kemp
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know.

14. INFORMANT Joseph G. Miller
(Address) R. R. Gallatin, Mo

15. Filed April 12, 1929 Mrs. L. L. Henderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April-11-1929

17. I HEREBY CERTIFY, That I attended deceased from April 11th 1929 to April 11th 1929 that I last saw h..... alive on April 11th 1929, and that death occurred, on the date stated above, at 1:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

15 M Coa bundle

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 152 A

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF No
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. M. Graham, M. D
, 19 (Address) Jameson Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Jamesport, Masonic
DATE OF BURIAL 4/14- 1929

20. UNDERTAKER H. A. Hope
ADDRESS Gallatin

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.