

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JUN 23 1933

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

Do not use this space.

1. PLACE OF DEATH  
 59 County Livingston Registration District No. 508  
 1 Township \_\_\_\_\_ Primary Registration District No. 3026 File No. 17088  
 7 City Chillicothe Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_ Registered No. 68  
 2. FULL NAME Ray Wayne Hatfield  
 (a) Residence, No. 212 Sale St. 3 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**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 14 1932  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
11 15  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home  
 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) Fort Scott Kans  
 MOTHER FATHER  
 13. NAME Linnis Hatfield  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chillicothe Mo  
 15. MAIDEN NAME Thelma Dick  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo  
 17. INFORMANT Linnis Hatfield (ADDRESS) Chillicothe Mo  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Edgewood DATE 5-30 1933  
 19. UNDERTAKER F. B. Norman (ADDRESS) Chillicothe Mo  
 20. FILED 5/29 1933 R. Barney Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 29 1933  
 22. I HEREBY CERTIFY, That I attended deceased from May 29 1933, to May 29 1933  
 I last saw her alive on May 29 1933. Death is said to have occurred on the date stated above, at 11 a. m.  
 The principal cause of death and related causes of importance were as follows:  
Scarlet Fever Date of onset 5/29/33  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Symptoms. Was there an autopsy? NO  
 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? NO  
 If so, specify \_\_\_\_\_  
 (Signed) R. Gallery \_\_\_\_\_, M. D.  
 (Address) Chillicothe Mo

