

DEC 14 1937

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

Do not use this space.

## 1. PLACE OF DEATH

County *Adair*Registration District No. *4*File No. *40520*Township *Windsor*Primary Registration District No. *3001*Registered No. *219*City *Windsorville* (No. *1*)Hospital *Green Smith Hospital* (Ward)

## 2. FULL NAME

(a) Residence, No. *John W Hayes* St. *Edina Mo*

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *5* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *wh* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *m*5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Nellie Hayes*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 4, 1873*7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *64 3 16*8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Banking*

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) *Granger Mo*13. NAME *John Hayes*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*15. MAIDEN NAME *Ann Lynch*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*17. INFORMANT (ADDRESS) *Mrs Kate McGraw*18. BURIAL, CREMATION, OR REMOVAL PLACE *Edina, Mo* DATE *Nov. 20, 1937*19. UNDERTAKER (ADDRESS) *J. H. Wray, Edina, Mo.*20. FILED *Nov 20 1937* *Spencer Seeman* Registrar.21. DATE OF DEATH (MONTH, DAY, AND YEAR) *NOV 30, 1937*22. I HEREBY CERTIFY, That I attended deceased from *15 Nov*, 1937 to *20 Nov*, 1937I last saw him alive on *20 Nov*, 1937 Death is said to have occurred on the date stated above, at *355 P* m.

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

*Coronary Infarction* Date of onset *11/15/37*Other contributory causes of importance: *44B*Name of operation *none* Date ofWhat 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? 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) *E. E. Smith*, M. D.(Address) *Windsorville Mo*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

