

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.

REC'D MAY 18 1939

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

14725
Do not use this space.

1. PLACE OF DEATH 2

(a) County Wallas Registration District No. 245

(b) Township Lincoln Primary Registration District No. 5339

(c) City Wallas (d) Street No. _____ Registered No. 5

(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 Susie E. Hayes

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF A. H. Hayes

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 13-1853

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>85</u>	<u>4</u>	<u>26</u>	

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

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) Mo.

FATHER

13. NAME Francis M. Scott

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

MOTHER

15. MAIDEN NAME May Hayes

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

17. INFORMANT Sus. Hayes (ADDRESS) Walla Walla St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Mount DATE 4-9-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. B. Jones Walla Walla

20. FILED May 8, 1939 E. C. Williams Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-8-39

22. I HEREBY CERTIFY, That I attended deceased from 3/2 to 4/8

I last saw her alive on 3/2 Death is said to have occurred on the date stated above, at 9:30 a.m.

The principal cause of death and related causes of importance were as follows:
Excimeria meningitidis Date of onset 1935

Other contributory causes of importance: 50

Name of operation None Date of _____

What test confirmed diagnosis Stain 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? _____
If so, specify _____ (Signed) L. Glover, M. D.
Walla Walla (Address) Mo

RECEIVED

District Health Officer No.
District File Number 7-35-79
Date Filed 5-11-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.