

Registration District No. 5-20 13

Primary Registration District No. 57625

Registrar's No. 93

1. PLACE OF DEATH: *Mississippi*
(a) County *Mississippi*
(b) City or town *Highway at the Rural*
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution *33 yrs*
In this community *33 yrs*
years, months or days (Specify whether

2. USUAL RESIDENCE OF DECEASED:
(a) State *Missouri* (b) County *Mississippi*
(c) City or town *Cross*
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME *ARB LEE HALEY*
8. (b) If veteran, name war. *✓*
8. (c) Social Security No. *✓*

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *Sept.* day *10*
year *1939* hour *2:30* minute *9* M.

4. Sex *Male* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *Married*
6. (b) Name of husband or wife *Hazel Helen Haley* 6. (c) Age of husband or wife if alive *18* years
7. Birth date of deceased *Dec. 25 1907*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *View Jackson* 19____
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

8. AGE: Years *33* Months *8* Days *14* If less than one day hr. min.

Due to *Killed by Auto truck near Hwy at Mo. on*
Due to *Highway 60 - 1st ramp onto the truck with his car*
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations *g/10 IV*
Of autopsy *g/10 IV*

9. Birthplace *Cross, Missouri*
(City, town, or county) (State or foreign country)
10. Usual occupation *Farming*
11. Industry or business *BSWA*
12. Name *Ben Haley*
13. Birthplace *Kentucky*
(City, town, or county) (State or foreign country)
14. Maiden name *Fathy Hudson*
15. Birthplace *Kentucky*
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) *accident*
(b) Date of occurrence *Sept-10th 1939*
(c) Where did injury occur *Highway 60 East of Hwy at Mo*
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on Highway 60
(Specify type of place) (e) Means of injury _____

MOTHER FATHER
16. (a) Informant's own signature *A. C. Haley*
(b) Address *Columbus, Ky*
17. (a) *Burial* (b) Date thereof *Sept 11-39*
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation *New Chapel Clinton*
18. (a) Signature of funeral director *David N. Shelly*
(b) Address *East Orange Mo*
19. (a) *9-13-39* (b) *F. B. Shelly*
(Date received local registry) (Registrar's signature)

23. Signature *Frank S. Vernon* (M. D. or other) *Coroner*
Address *Charleston Mo* Date signed *9-13-39*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

V. S. C. 2.
50M-5-17-39
Rev. 5-17-39
G. I. Kestel

RECEIVED

District Health Officer No. 2

District File Number 1039-224

Date Filed 10-3

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.