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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JUN 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43440

Registration District No. 318 — Primary Registration District No. 5440 — Registrar's No. 904

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Medical Center for Federal Prisoners 3 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5months 8 days (Specify whether

In this community same years, months or days)

2. USUAL RESIDENCE OF DECEASED: 2

(a) State OKLAHOMA (b) County Tulsa

(c) City or town Tulsa (If outside city or town limits, write "RURAL")

(d) Street No. 432 E. King Street (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME HAYES, Clyde 200

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex Male — 5. Color or race Negro — 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased March (Month) 28th (Day) 1919 (Year)

8. AGE: Years 20 — Months 8 — Days 13 — If less than one day ..... hr. ..... min.

9. Birthplace Cleveland (City, town, or county) Ohio (State or foreign country)

10. Usual occupation Waiter 1

11. Industry or business Hotel 1

FATHER
12. Name HAYES, Ed. 1
13. Birthplace Unknown (City, town, or county) Oklahoma (State or foreign country) 0

MOTHER
14. Maiden name WILLIAMS, Ella
15. Birthplace Unknown (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Deceased.

(b) Address

17. (a) East Lawn Cem (Burial, cremation, or removal) (b) Date thereof 12-14-39 (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Mo.

18. (a) Signature of funeral director Theime Funeral Home

(b) Address Springfield, Mo.

19. (a) 12-14-39 (Date received local registrar) (b) Chas A. George MD (Registrar's signature) RJB

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 11th year 1939 hour 2:45 P.M. minute ..... M.

21. I hereby certify that I attended the deceased from July 3rd, 1939, 19..., to Dec. 11, 1939, 19...; that I last saw him alive on Dec. 11, 1939, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary tuberculosis	Apr. '39
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy No autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) - - - - - -

(b) Date of occurrence - - - - - - - - - - -

(c) Where did injury occur? - - - - - - - - - - (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? No (e) Means of injury .....

23. Signature E W Green (M. D. or other) 1

Address MCFP, Springfield, Missouri Date signed 1

(Licensed Embalmer's Statement on Reverse Side)

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 Self, Registered Apprentice No. ..... working under my personal supervision.

Signed Ralph Thieme

Licensed Embalmer No. 5681

P. O. Address Sp. Mo.

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

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