

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

Do not use this space.

7239

FEB MAR 14 1940

1. PLACE OF DEATH

County *divingston* Registration District No. *1076*
Township *Grand River* Primary Registration District No. *5681*
City *Hale, mo* (No. *8*) St. _____ Ward _____

2. FULL NAME

David Williamson Hale R. #10#1 Ward _____
(a) Residence, No. *Hale 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. 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: *single*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *August 9 - 1878*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. of min.
61 6 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *retired merchant*
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

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Platt City, Mo*

13. NAME *John T. Hayes*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*

15. MAIDEN NAME *Mary C. Fisher*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Virginia*

17. INFORMANT *Millard Milhollin*
(ADDRESS) *Hale Missouri*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Platt City Cem.* DATE *Feb 25* 19*40*

19. UNDERTAKER *Frank E. Slater*
(ADDRESS) *Hale mo*

20. FILED *Feb 22* 19*40* *Mr. Chas. Ludwig* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 23* 19*40*
22. I HEREBY CERTIFY, That I attended deceased from *Feb 4* 19*40* to *Feb 23* 19*40*
I last saw him alive on *Feb 23* 19*40* Death is said to have occurred on the date stated above, at *119* m.
The principal cause of death and related causes of importance were as follows:

Fever
g2w
Other contributory causes of importance:
mitral insufficiency
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ 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) *wpk* _____ M. D.
(Address) *Hale mo*

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.

100M-3-28-35

RECEIVED

District Health Officer No. 11,

District File Number 340-325

Date Filed MAR 12 1940

RECEIVED
MAR 12 1940
DISTRICT HEALTH OFFICER NO. 11

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7239**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. **1076**

Primary Registration District No. **3681**

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Livingston**
(b) City or town **Grand River Rural**
(If outside city or town limits, write "RURAL" and name of township)
(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..... (Specify whether
In this community..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Livingston**
(c) City or town **Hale Mo. P.R.#1**
(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.

3. (a) PRINT FULL NAME **Daniel Williamson Hays**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years **61** Months **6** Days **14** If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **Feb 25 1940** (b) **Mrs. Chas. Ludwig**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Feb** day **23** year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....; that I last saw h..... alive on..... 19..... and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of 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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature **W. P. Kemp** (M. D. or other).....

Address **Hale Mo** Date signed.....

SUPPLEMENTAL

