

BUREAU OF VITAL STATISTICS
SEP 20 1940
Registration District No. 477Primary Registration District No. 200Registrar's No. 31

1. PLACE OF DEATH:

(a) County Lewis
 (b) City or town Rural - LaBelle Twp.
 (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) 2
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 72 yrs. - 2 - mo - 19 day
 years, months or days)

3. (a) PRINT FULL NAME

Margaret E. Hayden3. (b) If veteran,
name war no3. (c) Social Security
No. None4. Sex Female5. Color or
race White6. (a) Single, widowed, married,
divorced Widowed6. (b) Name of husband or wife
Harvey Hayden6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased May
(Month)13
(Day) 1868
(Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>2</u>	<u>19</u>	hr. min.

9. Birthplace near LaBelle, Lewis Co. Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Housekeeping

11. Industry or business

12. Name Isaac Sutton13. Birthplace Penn.
(City, town, or county) (State or foreign country)14. Maiden name Maria Thomas15. Birthplace Penn.
(City, town, or county) (State or foreign country)16. (a) Informant Prof. S. Hayden(b) Address LaBelle Mo.17. (a) Burial (b) Date thereof 8 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation LaBelle Cemetery18. (a) Signature of funeral director James T. Roberts

(b) Address _____

19. (a) Aug 3 (b) P. W. Jennings M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis
 (c) City or town Rural
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug, day 25th,
year 1940, hour 11, minute 30 P.M.21. I hereby certify that I attended the deceased from July 30th
1940 to July 22, 1940
that I last saw him alive on July 29th and that death occurred on the date and hour stated above.Immediate cause of death Heart failure
from old perforation Duration 4 days

Due to _____

Due to _____

Other conditions Thrombophlebitis
(Include pregnancy within 3 months of death)Major findings:
Of operations ✓

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 A. H. S. Sutton (M. D. or other) _____Address LaBelle Mo. Date signed 8/14/40

82 D

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.....

Norman D. Loder

Registered Apprentice No.

working under my personal supervision.

Signed *Norman D. Loder*

Licensed Embalmer No. *3721*

P. O. Address *LaBelle, Mo*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File **289667**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **477**

Primary Registration District No. **200**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Lewis**
(b) City or town **Laballet, P.**
(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

3. (a) PRIOR FULL NAME **Margaret E. Haydon**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **w** 6. (a) Single, widowed, married divorced **wid**
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year
7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years **72** Months **2** Days **19** 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 _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **2**
year **1965** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____ 19____ to _____ 19____;
that I last saw him alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart failure** Duration _____

Due to _____

Due to _____

Other conditions **Hemiplegia 6 yrs.**
(Include pregnancy within 6 months of death)
Caused by cerebral hemorrhage

Major findings: _____
Of operations _____

Of autopsy **gsh**

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 **A. H. Lewis** (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL

