

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

35845

Registration District No. 566

Primary Registration District No. 3030

State File No. \_\_\_\_\_

Registrar's No. 140

1. PLACE OF DEATH: Mississippi  
(a) County \_\_\_\_\_  
(b) City or town Charleston  
(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 All of life  
years, months or days

3. (a) PRINT FULL NAME Betty Sue Hayden  
3. (b) If veteran, name war Infant  
3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced infant  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 24, 1940  
(Month) (Day) (Year)

8. AGE: Years 0 Months 4 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Infant

11. Industry or business XX

12. Name Pershing Hayden

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

14. Maiden name Pearl Wilson

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

16. (a) Informant Mrs R. L. Hayden

(b) Address Bertrand Mo., R#1

17. (a) Burial (b) Date thereof 10/28/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston, Mo Calvary

18. (a) Signature of funeral director Lair-Nunnelee

(b) Address Charleston, Mo

19. (a) 10-27-40 (b) J. D. Vernon  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Mississippi  
(c) City or town Bertrand, Mo R#1  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27<sup>th</sup>  
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 Drove there to death while asleep in bed

Due to found dead in bed

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 10-27-40

(c) Where did injury occur? at home Charleston, Miss Mo  
(City or town) (County) (State)

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

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Frank J. Vernon (M. D. or other) \_\_\_\_\_

Address Charleston, Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 2,  
District File Number 1140-165  
Date Filed 11/6/40

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**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 35-845-

Registration District No. 266

Primary Registration District No. 3030

Registrar's No. 140

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

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Charleston Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
507 W Commercial St  
(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 Mo. (b) County Miss.  
(c) City or town Bertrand Mo A.H.  
(If outside city or town limits write "RURAL")  
(d) Street No. Charleston Mo  
507 W Commercial St (If not give location)  
(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Betty Sue Hayden

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

4. Sex..... 5. Color or race..... 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 Months Days If less than one day  
0 4 3 min.

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

10. Usual occupation.....

11. Industry or business.....

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) 4-11-41 (Date received local registrar) (b) F S Vernon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... month..... day..... year..... 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.....  
Smoked to death while asleep in bed

Due to.....  
Found dead in bed

Due to.....

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

Major findings: Of operations.....

Of autopsy.....

1940  
15

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

(a) Accident, suicide, or homicide (specify)..... acc

(b) Date of occurrence 10-27-1940

(c) Where did injury occur? at home Charleston Mo (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 Frank S. Vernon (M. D. or other) Address Charleston Date signed.....

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

