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STANDARD CERTIFICATE OF DEATH

State File No. 36023

Registration District No. 668 (116) Primary Registration District No. 3032 Registrar's No. 341

044

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

1. PLACE OF DEATH: *Pettis*

(a) County..... *Pettis*

(b) City or town..... *Sedalia*

(c) Name of hospital or institution: *Bothwell Hospital*
(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 *Pettis*

(c) City or town..... *Sedalia*
(If outside city or town limits, write "RURAL")

(d) Street No. *219 W 7*
(If rural, give location)

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

3. (a) PRINT FULL NAME *Oscar Francis Hayes*

3. (b) If veteran, name war..... 3. (c) Social Security No. *496-12-7079*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct* day *27* year *1940* hour *6* minute *55 A.M.*

21. I hereby certify that I attended the deceased from *10-20*, 19*40*, to *10-27*, 19*40*; that I last saw him alive on *10-27*, 19*40* and that death occurred on the date and hour stated above.

4. Sex *Male* 5. Color or race *White* 6. (a) Single, widowed, married, divorced *Married*

6. (b) Name of husband or wife *Della Hayes* 6. (c) Age of husband or wife if alive *54* years

7. Birth date of deceased *June 24, 1884*
(Month) (Day) (Year)

Immediate cause of death

Due to *Pernicious anemia* *10 yrs*

Due to *Pillagra* *2 wks*

Other conditions *BP*
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

56 *4* *3* ..hr. ..min.

9. Birthplace *Cooper Co Mo* *D*
(City, town, or county) (State or foreign country)

10. Usual occupation *Barber*

PHYSICIAN

Major findings: Of operations.....

Of autopsy.....

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business.....

12. Name *Joseph S. Hayes*

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

14. Maiden name *Elizabeth Knittle*

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

16. (a) Informant *Mrs Della Hayes*

(b) Address *Sedalia Mo*

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

(c) Place: burial or cremation *Burton Mo*

18. (a) Signature of funeral director *Mrs. Laughlin Bros*

(b) Address *Sedalia Mo*

19. (a) *10/28/40* (b) *Mrs. Harry Under*
(Date received local registrar) (Registrar's signature)

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 *J. M. Rodeman* (M. D. optional) *!*

Address *Sedalia Mo* Date signed *10-28-40*

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed

P. E. Baker

Licensed Embalmer No.

2419

P. O. Address

Seneca

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

State File No. **36023**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **668**

Primary Registration District No. **332**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Pettis**
(b) City or town **Sedalia**
(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
In this community (Specify whether years, months or days)

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.

3. (a) PRINT FULL NAME **Oscar Francis Hayes**

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 **m**

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 **56** Months **4** Days **3** If less than one day, hr. min.

9. Birthplace (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) **10-25-40** (Date received local registrar) (b) **Mrs. Harry Sneed** (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Oct** day **27** 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.....

Due to.....
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).....
(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) (c) Means of injury.....

23. Signature **M. Rademan** (M. D. or other) Address **Sedalia**

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

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

SUPPLEMENTARY

