

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.

AUG 11 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS 100
CERTIFICATE OF DEATH

24737
 Do not use this space.

1. PLACE OF DEATH
 (a) County Cape Girardeau Registration District No. 120-4
 (b) Township _____ Primary Registration District No. 5009 Registered No. _____
 (c) City Cape Girardeau (d) Street No. Southeast Missouri Hospital St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MARY LOUISA HAYDEN
 (a) Residence, No. ORAN MISSOURI St. Oran Mo
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOW

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ALVA HAYDEN

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APR 30 1874

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	67	2	22	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSE WIFE.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) SCOTT COUNTY MISSOURI
 13. NAME Joseph Thomas
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scott County Missouri

MOTHER
 15. MAIDEN NAME Magdalena Monz
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scott County Missouri

17. INFORMANT (ADDRESS) Mrs Wilber Smith (Daughter) Oran Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Oran Mo DATE July 25 41
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) P. J. Hessner Co Oran Missouri
 20. FILED 7-22-41 J. M. Thompson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JULY 22 1941
 22. I HEREBY CERTIFY, That I attended deceased from 7/21 1941, to 7/22 1941
 I last saw her alive on 7-22 1941 Death is said to have occurred on the date stated above, at 6:30 P. m.
 The principal cause of death and related causes of importance were as follows:
Surgical shock
1941
 Other contributory causes of importance:
 Name of operation Vaginal hysterectomy Date of 7-22-41
 What test confirmed diagnosis? _____ Was there an autopsy? no

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) W. J. Stevens M. D.
 (Address) Cape Girardeau Mo

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
3009

State File No. 24737

125

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Southeast Missouri 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

3. (a) PRINT FULL NAME Mary Louisa Hayden

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

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

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

7. Birth date of deceased April 30, 1874
(Month) (Day) (Year)

8. AGE: Years 67 Months 2 Days 22
If less than one day _____ min.

9. Birthplace Mo.
(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 _____
(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH: Month July day 22
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
to _____, 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 _____

Surgical shock

Due to Vaginal hysterectomy

Flashed external grade # 4

(non malignant)

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

Major findings: Vaginal Hysterectomy

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) (e) Means of injury _____

23. Signature W.H. Wrenn (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Indicate the cause to which death should be charged statistically.

