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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 9 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Bordeaux

State File No. 36800

Registration District No. 47

Primary Registration District No. 3167

Registrar's No. 368

1. PLACE OF DEATH:

(a) County Calloway

(b) City or town Rural Liberty Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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 Calloway

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. ..... (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

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3. (a) PRINT FULL NAME JAMES RILEY HAYES

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex M O

5. Color or race W

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife LENA HAYES

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased JULY (Month) 3 (Day) 1865 (Year)

8. AGE: Years 77 Months 3 Days 17 If less than one day ..... hr. ..... min.

9. Birthplace Boone Co (City, town, or county) Mo O (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Robt Hayes

FATHER
12. Name ROBERT HAYES
13. Birthplace Dk (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name ELIZABETH RENFRO
15. Birthplace Dk. (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs Wyoming
(b) Address Centralia Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (Month) 21 (Day) 1941 (Year)
(c) Place: burial or cremation Centralia Mo

18. (a) Signature of funeral director M S McDonald
(b) Address Centralia Mo

19. (a) ~~10-22-1942~~ 11-16-1942 (Date received local registrar) (b) Josie Moisinkhoff (Registrar's signature)

1147 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20 year 1942 hour 11 minute 15 A.M.

21. I hereby certify that I attended the deceased from 1935, 19..., to Oct 20, 1942, that I last saw him alive on Oct 19, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Melonoma (Malanotic Sarcoma)	2 years.
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Frank V Barden, MD (M. D. or other)

Address Centralia Date signed 10-21-42

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 M. J. McDonald

Licensed Embalmer No. 4313

P. O. Address Centralia Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

V. S. No. 2R
10M—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36800

Registration District No. 47 Primary Registration District No. 5167 Registrar's No. 363

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

1. PLACE OF DEATH:
(a) County: Callaway
(b) City or town: 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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: James Riley 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: July (Month) 3 (Day) (Year)
8. AGE: Years 77 Months 3 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (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) (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20 year 1942 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.

	Duration
Immediate cause of death: Melanoma (Malignant Lesion)	1 yrs.
Due to: Malignancy of Skin.	
Due to: Multiple Lesion of Skin.	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 53
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: Frank W. Barden, M.D. (M. D. or other)
Address: Centralia, Mo. Date signed

SUPPLEMENTARY

S-36800