1-4-41
5-17-39
I X26390

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

1601

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 25 1943 42

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 5

Primary Registration District No. ~~1001~~ 1000

Registrar's No. 40

1. PLACE OF DEATH:

(a) County: BUCHANAN

(b) City or town: ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital # 2.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 8 days (Specify whether years, months or days)

In this community: Same.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Lafayette

(c) City or town: Lexington
(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

3. (a) PRINT FULL NAME: FRANK. Hayden.

3. (b) If veteran, name war: no

3. (c) Social Security No.: unknown

4. Sex: M 2

5. Color or race: Col.

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife:

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

7. Birth date of deceased: unknown (Month) (Day) (Year)

8. AGE: Years: 42 Months: unk Days: unk If less than one day: hr. min.

9. Birthplace: Lexington (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Janitor work

11. Industry or business:

FATHER
12. Name: Hub Hayden
13. Birthplace: Ironton (City, town, or county) I (State or foreign country)

MOTHER
14. Maiden name: Jane Davis
15. Birthplace: Lexington (City, town, or county) I (State or foreign country)

16. (a) Informant: H. R. Green
(b) Address: Lexington Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Jan 14 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Lexington Mo

18. (a) Signature of funeral director: Grant Cope
(b) Address: 204 So 24th St Lexington Mo

19. (a) 1-14-43 (Date received local registrar) (b) Rose Alzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14th year 1943 hour 7 15 minute a M.

21. I hereby certify that I attended the deceased from Jan 6th 1943, 19, to Jan 14th 1943; that I last saw him alive on Jan 13-1943, 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Rupture of abdominal Aortic aneurysm.

Due to: unknown

Due to:

Other conditions: Cardiac Hypertrophy
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations:

Of autopsy: Rupture abdominal aorta aneurysm — Cardiac Hypertrophy

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: J. H. Deerhouse M.D. (M. D. or other)

Address: State Hosp #2. St Joseph Date signed: 1/14/43

1283 (Licensed Embalmer's Statement on Reverse Side)

FEB 4 1943

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 wi the above constitutes grounds for revocation of license.)

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

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1601

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 40

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St Joseph (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: Frank Hayden
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M
5. Color or race: B
6. (a) Single, widowed, married, divorced: S
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 42 Months 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 Day year 1943 hour minute M.
21. I hereby certify that I attended the deceased from 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: Rupture of abdominal aortic aneurysm	
Due to: unk	
Due to: non-specific	
Other conditions (Include pregnancy within 3 months of death): Cardiac Hypertrophy	

Major findings:
Of operations: No
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) no injury sustained
While at work? (e) Means of injury

23. Signature: L. H. Dunham (M. D. or other)
Address: St. Joseph Hospital St. Joseph Mo. Date signed

SUPPLEMENTARY