

REG APR 14 1943
Registration District No. 297

Primary Registration District No. 6022

Registrar's No. 6

1. PLACE OF DEATH: Ray
(a) County Richmond Mo. R.F.D.# 1
(b) City or town _____
(c) Name of hospital or institution None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
In this community None (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Ray
(c) City or town Hardin Mo. R.F.D.# 1
Rural (If rural, give location)
(d) Street No. _____
(e) Citizen of foreign country? No (Yes or No)
If yes, name country U.S.A.

3. (a) PRINT FULL NAME Nervia J. Hayes
3. (b) If veteran, no name war _____
3. (c) Social Security no No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 15th
year 1943 hour 11 minute 10 M.
21. I hereby certify that I attended the deceased from April
1942 to Mar 15 1943
that I last saw her alive on Mar 14 1943
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Low V. Hayes
6. (c) Age of husband or wife if alive YES years _____
7. Birth date of deceased March 31 st. 1837
(Month) (Day) (Year)

Immediate cause of death Carcinoma of liver
Due to Cause unknown
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: H&B
Of operations _____
Of autopsy _____

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>11</u>	<u>16</u>	hr. _____ min. _____

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? _____

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

10. Usual occupation House Wife

11. Industry or business Hiram Jackson

12. Name Mo.

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

14. Maiden name Polly Gauldine

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

16. (a) Informant E N Hayes

(b) Address Richmons Mo. R.#11

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation New Hope Ray Co. Mo.

18. (a) Signature of funeral director _____
(b) Address Richmond Mo.

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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

23. Signature GW Baine M.D. (M. D. or other) M.D.
Address Richmond, Mo. Date signed 3-16-43

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

17-39
X32873

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 4-12-43

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.....

J.B. Brothers

....., Registered Apprentice No.

working under my personal supervision.

Brothers Funeral Home .

Signed..... *J.B. Brothers*

Licensed Embalmer No. **2001**

P. O. Address **Richmond Mo.**

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. 11204
Registrar's No. 6

Registration District No. 297 Primary Registration District No. 6022

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

1. PLACE OF DEATH:

(a) County Ray
 (b) City or town Richmond
 (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 _____ years, months or days

3. (a) PRINT FULL NAME Nervia J. Hayes
 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 m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 3 (Month) (Day) (Year)

8. AGE: Years 55 Months 11 Days _____ If less than one day _____ min.

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

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) Mar 16 1943 (Date received local registrar) (b) Mrs. Sherrill W. Shippard (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1943 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____; that I saw him/her 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) (e) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

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

S-11204