

No. 2
9-4-41
17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Alvin 39298

State File No.

FILED DEC 15 1943

Primary Registration District No. 4482

Registrar's No. 49

1. PLACE OF DEATH:

(a) County scottland

(b) City or town memphis

(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 Entire Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County scottland

(c) City or town memphis (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

3. (a) PRINT FULL NAME Emma Austin Hayden

3. (b) If veteran, name war: ✓

3. (c) Social Security No. ✓

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced: 2

6. (b) Name of husband or wife: John P. Hayden

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

7. Birth date of deceased: Jan 30 1855 (Month) (Day) (Year)

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

88 9 17 hr. min.

9. Birthplace: Livingston Co Mo 0 (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

12. Name: Alexander Austin

13. Birthplace: King 1 (City, town, or county) (State or foreign country)

14. Maiden name: Franka Wilson

15. Birthplace: Livingston Co Mo 1 (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. G M Horn

(b) Address: Memphis Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov 18 43 (Month) (Day) (Year)

(c) Place: burial or cremation: Grain Cemetery

18. (a) Signature of funeral director: Berth Basket

(b) Address: Memphis Mo

19. (a) Nov 26, 1943 (Date received local registrar) (b) Bernice Nelson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 16 year 1943 hour 6 a m minute M.

21. I hereby certify that I attended the deceased from Dec 1942 to Nov 16 1943; that I last saw him alive on Nov 16 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Attack of Angina Pectoris Duration 30

Due to: Coronary Heart Disease

Due to:

Other conditions (Include pregnancy within 3 months of death): 94a

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

23. Signature: W. C. Alexander (M. D. or other) Address: Memphis Mo Date signed: 11-17-43

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

MOTHER FATHER

1095

(Licensed Embalmer's Statement on Reverse Side)

84
84

1 . VO . 29

RECEIVED
District Health Officer No. 10
District File Number 12-43-1920
Date Filed DEC 13 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 Fred Gert

Licensed Embalmer No. 4256

P. O. Address Memphis

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.

Registration District No. 326 Primary Registration District No. 4482

1. PLACE OF DEATH:
(a) County Scotland
(b) City or town Memphis
(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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Emma A. 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 widowed
6. (b) Name of husband or wife Peter Hayden 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 30 (Month) (Day) (Year)

8. AGE: Years 88 Months 9 Days _____ Unless than one day _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year 1993 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I last 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

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

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

S-39298