

No. 2
4-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27059

State File No. _____

FILED SEP 10 1944

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 223

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Grim-Smith Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Hour
Life (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Rural, No. 1, Novinger
(If outside city or town limits, write "RURAL")
(d) Street No. Rural No. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dental Joe Hays

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 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: Sept. 20 1938
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 10 25 hr. _____ min.

9. Birthplace Adair Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

12. Name Leland Hays

13. Birthplace Adair Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Frances Carter

15. Birthplace Adair Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Leland Hays

(b) Address Novinger, Mo.

17. (a) Burial (b) Date thereof 8/16/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Temple Cemetery

18. (a) Signature of funeral director B. Berkley

(b) Address Kirksville, Mo.

19. (a) 8-30-44 (b) Tom L. Wagner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 15
year 1944 hour 12:00 minute _____ P.M.

21. I hereby certify that I attended the deceased from Aug 15 1944 to Aug 15 1944
that I last saw h him on Aug 15 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Multiple fractures of skull Duration 1 hr

Due to _____

Due to _____

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

Major findings: 1702-21
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) accident 101

(b) Date of occurrence Aug 15, 1944

(c) Where did injury occur? Novinger, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Farm
(Specify type of place) (e) Means of injury _____

23. Signature D. Hays (M.D. or other) med

Address Novinger, Mo Date signed Aug 16

1049 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER, FATHER

RECEIVED

District Health Officer No. 10

District File Number 9-44-1527

Date Filed SEP 7 1944

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 D. E. Riley

Licensed Embalmer No. 4181

P. O. Address 12 Knolls Rd

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.