

FILED SEP 13 1944

Registration District No. 198

Primary Registration District No. 4310

Registrar's No. 60

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Bevier
(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 8 weeks
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town Bevier Mo
(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 Jennie A Hays

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1 year 1944 hour 10 minute A. M.

21. I hereby certify that I attended the deceased from Aug 20, 1944 to Sept 1, 1944
that I last saw h. ELZ alive on Aug 29, 1944
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife John C 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Nov 23 1862
(Month) (Day) (Year)

Immediate cause of death Cerebral Apoplexy Duration 2 weeks

Due to Hypertension heart disease

Due to Atherosclerosis

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

8. AGE: Years 81 Months 10 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation housekeeper

Major findings: 938

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name John Cook

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

14. Maiden name May E. Morland

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

16. (a) Informant E & H Hays

(b) Address _____

17. (a) Burial (b) Date thereof 9-3-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Unionville

18. (a) Signature of funeral director Summer Powell

(b) Address Unionville Mo

19. (a) 9-1-1944 (b) Winnie Rowland
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury _____

Signature P. K. Jenkins (M. D. or other) _____

Address Callao Date signed 9/1/44

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

MOTHER FATHER

12801

RECEIVED

District Health Officer No. 10

District File Number 9-44-1595

Date Filed SEP 12 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 W. C. Summers

Licensed Embalmer No. 2159

P. O. Address Keokuk 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Macon
 (b) City or town Bever
(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 Fannie A. Hays

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 W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 23
(Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days _____ If less than one day, _____ min.

9. Birthplace _____
(City, town, or county) (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 F. E. Hays

(b) Address Lavonia - Mo.

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-1-44 (b) Winne J. Rowland
(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 Sept Day 1 Year 1944 Hour 9 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. Immediate cause of death _____

Duration _____

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? _____

While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

28241