No. 2
1—2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 11 1944

Registration District No. 243

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4364

State File No. 384117

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Stella
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Cardwell Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days 0 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73

(c) City or town Neosho
(If outside city or town limits, write "RURAL")

(d) Street No. 435 E. Park
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Lawrence John Haley

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased October (Month) 25 (Day) 1912 (Year)

8. AGE: Years 31 Months 11 Days 16 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Clyde Haley
13. Birthplace Fairview (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Maud Ray
15. Birthplace Fairview (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Mrs. Clyde Haley
(b) Address 435 E. Park, Neosho Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Mice Cemetery

18. (a) Signature of funeral director Culver Funeral Home
(b) Address Carrville, Missouri

19. (a) 11-8-1944 (Date received local registrar) (b) Aepha R. Hale Dyer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11 year 1944 hour 5 minute P.M.

21. I hereby certify that I attended the deceased from 10-8- 1944, to 10-11- 1944 that I last saw him alive on 10-11- 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Angina Pectoris	3 days.
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature O. Cardwell (M. D. or other)

Address Stella Mo. Date signed 11/8/44

1317

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED DEC 7 1944
District Health Officer No.
District File Number 1144-243
Date Filed DEC 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 Margaret Culver

Licensed Embalmer No. 4389

P. O. Address Cassville

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec.

Registration District No. 243 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Stella
(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)

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 Lawrence J. Haley

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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 Oct (Month) 25 (Day) 19 (Year)

8. AGE: Years 31 Months 11 Days 12 If less than one day hr. min.

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

10. Usual occupation Postal Clerk

11. Industry or business Postal Clerk

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) Alpha L Hale Byer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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.

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(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

MAR 23 1945

38417