

FILED JAN 9 1945

Registration District No.

Primary Registration District No. 1000

Registrar's No. 1336

1. PLACE OF DEATH:

(a) County... Buchanan
(b) City or town... St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... 12 hrs - (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... Mo - (b) County... Buch - 11
(c) City or town... St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No... St. Joseph's Hosp!
(If rural, give location)
(e) Citizen of foreign country? New Born - 62 (Specify No)
If yes, name country...

3. (a) PRINT FULL NAME

Gloria June Hayes

3. (b) If veteran, name war

3. (c) Social Security No. 7444

4. Sex Female

5. Color or race wh

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: 12 - 11 - 44 (Month) (Day) (Year)

8. AGE: New Born (Years) (Months) (Days) If less than one day 11 - hr. 55 min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name Robert Eugene Hayes
13. Birthplace Mo - 0 (City, town, or county) (State or foreign country)
14. Maiden name Mildred Rose Hartman
15. Birthplace St. Joseph, Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mildred Hayes

(b) Address 801 So 11th

17. (a) Burial (b) Date thereof Dec - 13, 1944 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Agency Cemetery

18. (a) Signature of funeral director Mrs. F. R. DENFADENT

(b) Address 602 So. 10 Street

19. (a) 12-12-44 (Date received local registrar) (b) Helen H. Heble (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12 year 1944 hour 8 minute 25 a.M.

21. I hereby certify that I attended the deceased from 12-11-1944 to 12-12-1944

that I last saw her alive on 12-12-1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Trauma + Undeveloped

Due to 159

Due to

Other conditions: (Include pregnancy within 5 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 Sarah Hayden (M. D. or other)

Address 670 Spruce Date signed 12/14/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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. *Did not Embalmed*
Mollie E. Sidenfaden Fox

Licensed Embalmer No. *4235*

P. O. Address. *St. Joseph 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.