

FILED MAR 30 1945

Registration District No. 128

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: O'Reilly General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME CLIFFORD HAYS

3. (b) If veteran, name war World War I
World War II

3. (c) Social Security No. 446-09-4566

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Dorothy Dewey Hays

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

7. Birth date of deceased: April 12, 1901
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<input checked="" type="checkbox"/> 43	11	1	hr. _____ min. _____

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

10. Usual occupation Truck driver

11. Industry or business Francis Bros. Shows

12. Name John David Hays

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

14. Maiden name Mable Armeania O'Connell

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

16. (a) Informant Mrs. Dorothy B. Hays

(b) Address 516 South Ave., Spfld, Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 3/15/45
(Month) (Day) (Year)

(c) Place: burial or cremation National Mortuary Springfield, Missouri

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 3-14-45
(Date received local registrar)

(b) BY W.E. Handley
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 516 South Avenue
(If rural, give location)

(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12
year 1945 hour 8 minute 00 A.M.

21. I hereby certify that I attended the deceased from 3-12, 1945, to 3-12, 1945,
that I last saw him alive on March -12, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction Duration 10 min.

Due to Thrombosis, right coronary artery 15 min.

Due to Arteriosclerosis, coronary arteries ? years

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

Major findings: Of operations _____
Of autopsy Above conditions found.

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 William M. Kingston (M. D. or other) Dr. C. M. C.

Address O'Reilly General Hospital Date signed March 2, 1945

Copy furnished Bureau of the Census, Washington, D. C.

JUL 18 1956

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 *Walter E. Hamillan*

Licensed Embalmer No. *3808*

P. O. Address *Springfield 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.