No. 2
2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Dr. J.W. Whitaker

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10212

FILED MAR 26 1945

Registration District No. _____ Primary Registration District No. 4330 Registrar's No. 9

1. PLACE OF DEATH:

(a) County: Mississippi

(b) City or town: East Prairie, Mo. (If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) In this community 72 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Mississippi

(c) City or town: East Prairie, Mo. (If outside city or town limits, write "RURAL") 47

(d) Street No. _____ (If rural, give location) 2

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

If yes, name country _____

3. (a) PRINT FULL NAME: BARBARA ADELINE HAYES

3. (b) If veteran, name war: —

3. (c) Social Security No. None

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: William Thomas Hayes

6. (c) Age of husband or wife if alive: 77 years

7. Birth date of deceased: Sept. 11, 1861 (Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation: House wife

11. Industry or business _____

MOTHER FATHER

12. Name: Unknown

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

14. Maiden name: Unknown

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

16. (a) Informant: Joseph B. Bard

(b) Address: East Prairie, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-45 (Month) (Day) (Year)

(c) Place: burial or cremation: W.O.W.

18. (a) Signature of funeral director: Travis Shelby

(b) Address: East Prairie Mo.

19. (a) 3-10-1945 (Date received local registrar) (b) Sandie E. Bryman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 6 year 1945 hour 2.20 minute a. M.

21. I hereby certify that I attended the deceased from Jan 30, 1945, to Feb 6, 1945 that I last saw h. alive on Feb 5 - 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis

Due to: Arteriosclerosis

Due to: Nephritis

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

Major findings: Of operations _____ Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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: George W. Whitaker (M. D. or other)

Address: East Prairie Mo Date signed 2/6/45

1271

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No.
District File No. 345-44
Date Filed 3/4/45

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 Travis Shelby

Licensed Embalmer No. 2726

P. O. Address East Prairie 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.

. No. 2B
M—5-43
o 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. April

Registration District No. 218 Primary Registration District No. 4330 Registrar's No. 9

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town
(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 years, months or days)
In this community

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 Barbara A. Hayes
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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 21 1861 (Month) (Day) (Year)
8. AGE: Years 83 Months 4 Days 25 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country) Ky
10. Usual occupation
11. Industry or business
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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13 year 1945 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.

Immediate cause of death	Duration
Due to Chronic Nephritis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION
Of autopsy REQUESTED

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

131

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