S. No. 2
M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 9 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16148

Registration District No. 1 | Primary Registration District No. 3000 | Registrar's No. 128

1. PLACE OF DEATH:
(a) County: Adair
(b) City or town: Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stickler Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 days (Specify whether years, months or days)
In this community: Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Adair
(c) City or town: Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No.: 500 W. Pierce
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Ida L. Hatfield
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: Widowed
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: March (Month) 1 (Day) 1877 (Year)
8. AGE: Years 68 Months 2 Days 14 If less than one day: hr. min.
9. Birthplace: Adair Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Home
11. Industry or business:
FATHER 12. Name: Thomas H. Lay
FATHER 13. Birthplace: Schuyler Co. (City, town, or county) Missouri (State or foreign country)
MOTHER 14. Maiden name: Mary A. Baldwin
MOTHER 15. Birthplace: Unknown (City, town, or county) ~~5/18/45~~ (State or foreign country)
16. (a) Informant: Odie L. Hatfield
(b) Address: Kirksville, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation: New Harmony
18. (a) Signature of funeral director: DE Riley
(b) Address: Kirksville, Mo.
19. (a) 5-23-45 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 year 1945 hour 7/30 minute A. M.
21. I hereby certify that I attended the deceased from May 13 1945 to May 15 1945 that I last saw him alive on May 15 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: apoplexy — Duration
cerebral Hemorrhage — 2 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: R O Stickler (M. D. or other) MD
Address: Kirksville Mo Date signed 5-23-45

1044

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 6-45-916
Date Filed JUN 7 1945

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 D E Riley

Licensed Embalmer No. 4181

P. O. Address Kirkville 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.