

FILED AUG 13 1945

Registration District No. 53

Primary Registration District No. 3010

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
S.E.M.O. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Several Months (Specify whether)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott / 100
(c) City or town Blodgett / 6
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3. (a) PRINT FULL NAME Dixie Ann Hayes
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 30th
year 1945 hour 11 minute 15 A.M.

4. Sex F / 5. Color or race White
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Will Hayes (dec'd)
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 12th 1863
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 16 1945 to June 20th 1945
that I last saw her alive on June 20th 1945
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>5</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death Valvular heart disease nephritis
Due to _____
Due to _____

Duration several years

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

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

10. Usual occupation retired

Major findings: _____
Of operations _____
Of autopsy _____

11. Industry or business _____

12. Name William Clippard

13. Birthplace Oak Ridge Mo. (State or foreign country)

14. Maiden name Artie Crites (State or foreign country)

15. Birthplace Cape Gir. Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Wallace Clippard

(b) Address Blodgett, Mo.

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

(c) Place: burial or cremation Oak Ridge, Mo.

18. (a) Signature of funeral director John F. Amelie

(b) Address Blodgett, Mo.

19. (a) 7-7-45 (Date received local registrar) (b) F. H. Phelps (Registrar's signature)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 J. Cochran (M. D. or other)

Address Cape Girardeau Mo. Date signed 6/30/45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4
District File Number 845-970
Date Filed 8-10-45

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 John F. Hummel
Licensed Embalmer No. 3851
P. O. Address Charleston, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 53Primary Registration District No. 3010

Registrar's No.

1. PLACE OF DEATH:

- (a) County Cape Girardeau
 (b) City or town Cape Girardeau
 (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)3. (a) PRINT
FULL NAMEDixie Ann Hayer

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
- wid

6. (b) Name of husband or wife.

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

7. Birth date of deceased.
- Jan 12

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

8252

hr.

min.

9. Birthplace.

(City, town, or county)

(State or foreign country)

10. Usual occupation.

11. Industry or business.

12. Name.

13. Birthplace.

(City, town, or county)

(State or foreign country)

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)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
-
- year
- 1945
- hour minute M.

21. I hereby certify that I attended the deceased from to 19.....;

that I last saw him alive on 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death.

Duration

Due to Chronic nephritis
Cause undetermined

Due to.

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

Major findings:

Of operations.

Of autopsy. 12/12

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
- H Cochran
- (M. D. or other)
- H

Address.

Date signed.

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

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

FILED AUG 1

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