

FILED NOV 26 1945

Registration District No. 268

Primary Registration District No. 6248

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Richwood
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 65 ps
In this community 65 ps
years, months or days (Specify whether)

3. (a) PRINT FULL NAME

Patrick Hayes

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Julia Hayes
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased 3-16-1876
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 2
If less than one day hr. min.

9. Birthplace Richwood (City, town, or county) (State or foreign country) 0

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER
12. Name Joseph Hayes
13. Birthplace no
14. Maiden name Maria Flanagan
15. Birthplace no

16. (a) Informant Julia Hayes
(b) Address Richwood
17. (a) Cremation (b) Date thereof 10-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richwood
18. (a) Signature of funeral director Clayton
(b) Address St. Clair
19. (a) 10-19-45 (b) Hayes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington
(c) City or town Richwood
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 18
year 1945 hour 8 minute 40 P.M.
21. I hereby certify that I attended the deceased from 10-13
1945 to 10-17-1945
that I last saw him alive on 10-17 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to arteriosclerosis
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy no

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? _____
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature O. W. Parker (M.-D. or other) _____
Address Richwood Date signed 10-19-45

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

RECEIVED

District Health Officer No. 4

District File Number 1145-1254

Date Filed 11-5-45

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.....

Licensed Embalmer No.....

P. O. Address.....

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.