

S. No. 2
M-2.43
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37962**
Registrar's No. **65**

FILED NOV 28 1945
Registration District No. **217**

Primary Registration District No. **3543-**

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

1. PLACE OF BIRTH:

(a) County Mississippi

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

(c) Name of hospital or institution:
217 Rail Road Ave. 1
(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 1 yr 3 mo 10 days

3. (a) PRINT FULL NAME NORMA EUBENE HAYS

3. (b) If veteran, name war ✓

3. (c) Social Security No. none

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced ✓ D

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 30 1914
(Month) (Day) (Year)

8. AGE: Years 1 Months 3 Days 10 If less than one day hr. _____ min. _____

9. Birthplace Wolf Island, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Alex Hays

13. Birthplace Hickman, Ky.
(City, town, or county) (State or foreign country)

14. Maiden name Paul Hays

15. Birthplace Wolf Island, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Paul Hays

(b) Address Charleston, Mo.

17. (a) Burial (b) Date thereof 10-12-45
(City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove

18. (a) Signature of funeral director James Shelby

(b) Address East Prairie

19. (a) Oct 12-45 (b) Wm J. B. Indurant
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Mississippi

(c) City, or town Charleston
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10 year 1945 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 28 1944, to Oct 12 1945

that I last saw him alive on Oct 2 1945

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

Immediate cause of death Sarcoma of thigh

Due to _____

Due to 552

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Large tumor of thigh

Of operations _____

Of autopsy _____

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 Loy S. Conner M.D. (Date signed 23 Oct 45)

Address 800 1/2 Commercial Ave

1541

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 1145-324

Date Filed 11-9-45

FEB 18 1946

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.