

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

41317

Registration District No. 133

Primary Registration District No. 3022

State File No.

Registrar's No. 108

1. PLACE OF DEATH

(a) County Harrison
(b) City or town Bethany
(c) Name of hospital or institution Walker Hospital
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 1 day
In this community about 45 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME CHAS. F. HALEY

3. (b) If veteran, name war L 3. (c) Social Security No. 1

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Annie Haley 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased: Mar 27 1871
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 10 If less than one day hr. min.

9. Birthplace Vandalia Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Gardener

11. Industry or business

12. Name Marion Haley
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Lynch
(City, town, or county) (State or foreign country)
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Virgil Haley
(b) Address Bethany Mo.

17. (a) Burial (b) Date thereof Dec 10 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Allen Cemetery

18. (a) Signature of funeral director Joe E. Wheeler

(b) Address Bethany Mo.

19. (a) Dec 15 1945 (b) Zola Berries
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Harrison
(c) City or town Bethany
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 7
year 1945 hour 8 minute 0 M.

21. I hereby certify that I attended the deceased from Dec 8 to Dec 8 1945
that I last saw him alive on Dec 8 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations (30)

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 Ernest L. Wood (M.D. or other) 20

Address Bethany Mo. Date signed Dec 15 1945

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

MOTHER FATHER

RECEIVED

District Health Officer No. 11,

District File Number _____

Date Filed _____

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.