

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 140

Primary Registration District No. 3024

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Fayette
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lee Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 hours
In this community 3 months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard
(c) City or town Fayette (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. R. F. D.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -----

3. (a) PRINT FULL NAME Isabelle Wayland Hair

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Richard M. Hair 6. (c) Age of husband or wife if alive ----- years
7. Birth date of deceased March 30 1858
(Month) (Day) (Year)

8. AGE: Years 88 Months 1 Days 7 If less than one day hr. --- min.

9. Birthplace Howard Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business -----

12. Name James Wayland
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Analiza Arnold
15. Birthplace Howard Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Warren Hammond
(b) Address Fayette, Missouri

17. (a) Burial (b) Date thereof 5/10/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookfield Cemetery

18. (a) Signature of funeral director Ralph A. Carr
Fayette, Missouri
(b) Address

19. (a) 5-14-1946 (b) Dorothy Jean Cohen
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7
year 1946 hour 2:00 minute P. M.

21. I hereby certify that I attended the deceased from January 1946 to May 7 1946
that I last saw her alive on May 7 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Duration 6 mos.

Due to Age
Due to -----

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

Major findings: Of operations none
Of autopsy none

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) (c) Means of injury -----

23. Signature Mrs J. Shaw (M. D. or other) M.D.
Address Fayette, Mo. Date signed 5-10-46

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

15368

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 6-10-46.....

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 Ralph A. Carr.....

Licensed Embalmer No. 3340.....

P. O. Address Jayette 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.