

FILED JUN 12 1946
STANDARD CERTIFICATE OF DEATH

State File No. **19522**

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **644**

1. PLACE OF DEATH:
 (a) County **Buchanan**
 (b) City or town **St Joseph**
 (c) Name of hospital or institution: **State Hosp # 2**
 (d) Length of stay: In hospital or institution **8 days**
 In this community **Years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Buchanan**
 (c) City or town **St Joseph**
 (d) Street No. **814 Cordell St St Joseph**
 (e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **William H Hayes**
 3. (b) If veteran, name war **---** 3. (c) Social Security No. **---**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **5**
 year **1946** hour **3-45** minute **a** M.

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced, mar.
 6. (b) Name of husband or wife **Mary E Hayes** 6. (c) Age of husband or wife if not stated
 7. Birth date of deceased **Not given**

21. I hereby certify that I attended the deceased from **May 26** 19**46** to **May 30** 19**46**
 that I last saw **him** alive on **May 30** 19**46**
 and that death occurred on the date and hour stated above.
 Immediate cause of death **Bronchial pneumonia**

8. AGE: Years **86** Months **✓** Days **✓** If less than one day **1** hr. min.

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

9. Birthplace: **Not given** (City, town, or county) (State or foreign country)
10. Usual occupation: **laborer**

MOTHER FATHER
11. Industry or business: **---**
12. Name: **Mar G. Hayes**
13. Birthplace: **St Joseph** (City, town, or county) (State or foreign country)
14. Maiden name: **---**
15. Birthplace: **---** (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
 Major findings: Of operations **107**
 Of autopsy **---**

16. (a) Informant: **Mr. Wm H Hayes**
(b) Address: **814 Cordell St St Joseph Mo**
17. (a) Burial (b) Date thereof **June 5 - 4 - 46**
(c) Place: burial or cremation: **Memorial Park**
18. (a) Signature of funeral director: **Fleeman & Son Inc**
(b) Address: **St Joseph Mo**
19. (a) June 5, 1946 (b) **---**
 (Date received local registrar) (Registrar's signature)

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: **L. A. Shuck** (M. D. or other) **---**
 Address **St Joseph #2 St Joseph** Date signed **5/20/46**

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

18998

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..... *Robert H. Gable*

Licensed Embalmer No. *3308*

P. O. Address..... *St. Joseph, 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.