

No. 2
-5-43
5-17-39
I X3667

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30891

State File No. _____

FILED SEP 16 1946

Registration District No. _____

Primary Registration District No. 3038

Registrar's No. 92

1. PLACE OF DEATH:

(a) County... Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
527 E. Prairie Street /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 50 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME James Clarence Hayes

3. (b) If veteran, name war... None 3. (c) Social Security No. 707-09-5213

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
7. (b) Name of husband or wife Clara Gray 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased December 12 1877
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 20 If less than one day
.....hr.min.

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

10. Usual occupation Crossing flagman-retired
C.B. & Q.R.R.

11. Industry or business C.B. & Q.R.R.

MOTHER FATHER

12. Name John Hayes

13. Birthplace Bucklin, Missouri ()
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Williams

15. Birthplace Glasgow, Missouri ()
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. C. Hayes
(b) Address Brookfield, Mo.

17. (a) Burial (b) Date thereof 9-5-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rose Hill Cemetery
Rusk Funeral Home

18. (a) Signature of funeral director
(b) Address Brookfield, Mo.
19. (a) 9/3/46 (b) W. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58
(c) City or town Brookfield /
(If outside city or town limits, write "RURAL")
(d) Street No. 527 E. Prairie 2
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2
year 1946 hour 6 minute 30 p. M.

21. I hereby certify that I attended the deceased from 9-2
1946 to 9-2 1946
that I last saw h. in alive on 9-2 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Vasculature Duration
accident 2 hrs

Due to Generalized arteriosclerosis

Due to.....

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

Major findings:
Of operations..... 83P
Of autopsy.....
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)
Means of injury.....

23. Signature Joseph H. Dilworth (M. D. or other)
Address Brookfield Mo. Date signed 9/3/46

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

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**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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..... *Harold B. Wright*

Licensed Embalmer No. *3718*

P. O. Address. *Brookfield, 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.