

V. S. No. 2
DOM-8-43
Rev. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 26 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36247**
Registrar's No. **376**

Registration District No. **47**

Primary Registration District No. **3008**

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

1. PLACE OF DEATH:
(a) County **Callaway**
(b) City or town **Fulton**
(c) Name of hospital or institution: **State Hospital No. 1. 2**
(If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or institution **5 years 5 months 10 days**
In this community **same**
years, months or days

3. (a) PRINT FULL NAME **ELIZABETH JANE HAYS.**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F.** / 5. Color or race **W.**
6. (a) Single, widowed, married, divorced. **Wid. 2**
6. (b) Name of husband or wife **D.K.** 6. (c) Age of husband or wife if alive **D.K.** years
7. Birth date of deceased. **6 11 1867**
(Month) (Day) (Year)

8. AGE: Years **79** Months **5** Days **5** If less than one day hr. _____ min. _____

9. Birthplace **Rally County Mo. 0**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

11. Industry or business _____
MOTHER FATHER { 12. Name **D.K.** /
13. Birthplace **D.K.** /
14. Maiden name **D.K.** /
15. Birthplace **D.K.** /
(City, town, or county) (State or foreign country)

16. (a) Informant **Hospital No. 1 Records**
(b) Address **Fulton Mo.**
17. (a) **Burial** (b) Date thereof **Nov. 19. 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Norton Cemetery**
18. (a) Signature of funeral director **Glen G. Thompson**
(b) Address **412 East Fulton Mo.**
19. (a) **Nov. 17. 1946** (b) **Jane Marsusky**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Marion**
(c) City or town **Hannibal** /
(If outside city or town limits, write "RURAL")
(d) Street No. **616 Church St.** /
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **11** day **16**
year **1946** hour **7.40** minute **9** M.
21. I hereby certify that I attended the deceased from **11-13-46** 19.46 to **11-16** 19.46
that I last saw h. **ER** alive on **11-15** 19.46
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: **93D**
Of operations _____
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)
(e) Means of injury _____
Signature **R.P. Price** (M.D. or other) _____
Address **Fulton Mo** Date signed **11-16/46**

67 H. Mayo

Handwritten mark resembling a stylized 'D' or 'U'.

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 11-25-46

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 Glen G. Maujain
Licensed Embalmer No. 2725
P. O. Address Fulton, 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.