

FILED FEB 28 1947

Registration District No. 247

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4366

State File No. 5598

Registrar's No. 8

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

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Granby
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Newton 73
(c) City or town Granby Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARY CATHERINE 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 MARRIED
6. (b) Name of husband or wife JOHN HAYS 6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased Dec. 7 1869
(Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace Licking Mo
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER

12. Name Henry Keeney D

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

14. Maiden name Jane Roberts

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

16. (a) Informant Agnes Hechathorne

(b) Address Granby Mo

17. (a) _____ (b) Date thereof Feb 19 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Granby Mo

18. (a) Signature of funeral director Charles - Judd

(b) Address Granby Mo

19. (a) 2-19-47 (b) M. L. Young
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 19 year 1947 hour 2:45 minute _____ A. M.
21. I hereby certify that I attended the deceased from 1944 to Feb 19 1947
that I last saw her alive on Feb 18 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-renal hypertensive disease Duration 3 yrs

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

Major findings: Of operations _____ Of autopsy 930

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 2

23. Signature Charles O. Chester (M. D. or other) D.O.
Address Granby Mo Date signed 2-19-47

225

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. Newton
District File Number 247-46
2-26-47

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 Margaret Culver
Licensed Embalmer No. 4389
P. O. Address Cassville

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.