

FILED JUN 4 1947

Registration District No. 305

Primary Registration District No. 6047

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County ST. CHARLES  
(b) City or town O'FALLON RURAL  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community Life \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County ST. CHARLES  
(c) City or town O'FALLON RURAL  
(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 GREGORY J. HAYDEN

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased JAN. 28 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
80 3 14 hr. \_\_\_\_\_ min.

9. Birthplace ST. PAUL MO  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_

12. Name LEYDEN HAYDEN

13. Birthplace PIKE CO. MO  
(City, town, or county) (State or foreign country)

14. Maiden name BOWLES

15. Birthplace ST. PAUL MO  
(City, town, or county) (State or foreign country)

16. (a) Informant MISS FABIOLA HAYDEN

(b) Address O'FALLON MO

17. (a) BURIAL (b) Date thereof 5-15-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. PAUL MO

18. (a) Signature of funeral director E. Smith

(b) Address 0740 N. Mo.

19. (a) 5-26-47 (b) Ma Jesus Lewis  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5-12 day May  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 3 May  
1947 to 12 May 1947  
that I last saw him alive on 3 May 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis 10 yrs

Due to generalized arteriosclerosis 20 yrs

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 Lawrence Baker (M. D. or other) \_\_\_\_\_  
Address O'Fallon Mo Date signed 13 May 47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

72  
6  
0

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed JUN 3 1947

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 Ed Keithly  
Licensed Embalmer No. 877  
P. O. Address Atellan 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.