

1. PLACE OF DEATH

(a) County Miller
(b) City or town Cedars
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
715 E. North St. 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 Miller
(c) City or town Cedars
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MASON HAYNES

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

4. Sex Male 5. Color or White
6. (a) Single, widowed, married, divorced Married

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased January 30 1875
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 24
If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name James M. Haynes

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

14. Maiden name Mary E. Stephens

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

16. (a) Informant Mrs. M. Haynes

(b) Address Cedars, Mo.

17. (a) Burial (b) Date thereof 8-26-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Plasil's Cemetery

18. (a) Signature of funeral director S. D. Phillips

(b) Address Cedars, Mo.

19. (a) 8-26-1947 (b) Elizabetha Walt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 24
year 1947 hour 5 minute 15 P.M.

21. I hereby certify that I attended the deceased from Aug 10
1947 to Aug 24 1947
that I last saw him alive on Aug 12 1947
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy
arteriosclerosis
Due to _____

Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

Duration

1 wk

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? 0

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature G. D. Walker (M. D. or other) _____
Address Cedars, Mo. Date signed 8/27/47

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 9-8-47

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.....

Jouis D. Phillips, Registered Apprentice No.....
working under my personal supervision.

Signed *Jouis D. Phillips*

Licensed Embalmer No. *3663*

P. O. Address *Weymouth*

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.