

1. PLACE OF DEATH:
 (a) County **PETTIS**
 (b) City or town **SEDALIA**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
BOTHWELL HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 In this community **40 YEARS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **PETTIS**
 (c) City or town **SEDALIA**
(If outside city or town limits, write "RURAL")
 (d) Street No. **908 E 7TH ST**
(If rural, give location)
 (e) Citizen of foreign country? **0** (Yes or No)
 If yes, name country _____

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **8**
 year **1947** hour **7** minute **40 P.** M.
21. I hereby certify that I attended the deceased from
Sept 6, 19**47**, to **Sept 8**, 19**47**
 that I last saw h. **ea** alive on **Sept 8**, 19**47**
 and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WID.**
 6. (b) Name of husband or wife **E. M. HAYS** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **12 7 1874**
(Month) (Day) (Year)

Immediate cause of death **Anemia, Tuberculosis**
 Due to **unknown**
 Due to _____

8. AGE: Years **72** Months **9** Days **1**
 If less than one day hr. _____ min. _____

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: **13A**
 Of operations _____
 Of autopsy **Hypoglycemia, Dementia**

9. Birthplace **SWEDEN**
(City, town, or county) (State or foreign country)
 10. Usual occupation **AT HOME**

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 11. Industry or business _____
 12. Name **ANDERSON**
 13. Birthplace **SWEDEN**
(City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Edna Schott**
 (b) Address **Sedalia, Mo**

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? _____

17. (a) **Burial** (b) Date thereof **9-10-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Crown Hill**

While at work? _____ (Specify type of place) (e) Means of injury **0**

18. (a) Signature of funeral director **Geo Dickard**
 (b) Address **Sedalia, Mo.**
 19. (a) **9/9/47** (b) **Betty Yeager**
(Date local registrar) (Signature of local registrar)

23. Signature **A. P. Edwards** (M. D. or other) **MD**
 Address **Sedalia, Missouri** Date signed **9/9/47**

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

80
6
4

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed.....12-2-47

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 *John A. Carlton*
Licensed Embalmer No. *4387*
P. O. Address *Sedalia, 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.