

FILED MAY 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11464

BIRTH NO. _____ REG. DIST. NO. 30 PRIMARY REG. DIST. NO. 4038 Registrar's No. 12

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| 1. PLACE OF DEATH a. COUNTY <u>Benton</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WARSAW</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WARSAW</u> | |
| c. LENGTH OF STAY (in this place) <u>14 years</u> | | d. STREET ADDRESS (If rural, give location) _____ | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>✓ 1</u> | | | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Laura</u> b. (Middle) <u>B</u> c. (Last) <u>Hailey</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 20 1949</u> |
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|----------------------|---------------------------|---|------------------------------------|---|---|---|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>FEB 8 1876</u> | 9. AGE (In years last birthday) <u>73</u> | 10. UNDER 1 YEAR Months <u>2</u> Days <u>12</u> | 11. UNDER 1 MRS. Hours _____ Min. _____ |
|----------------------|---------------------------|---|------------------------------------|---|---|---|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (State or foreign country) <u>O Benton County</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
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| 13a. FATHER'S NAME <u>William Flippen</u> | 13b. MOTHER'S MAIDEN NAME <u>JANE UNKNOWN</u> | 14. NAME OF HUSBAND OR WIFE <u>Joseph H. Hailey</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No NONE</u> | 16. SOCIAL SECURITY NO. <u>NO</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Joe Hays HAILEY Warsaw</u> |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>—</u> | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>—</u> | | 3 | |

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| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>331X</u> |
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| | | |
|---|--|----------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? _____ |
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22. I hereby certify that I attended the deceased from 10 Aug 1948 to 20 April 1949, that I last saw the deceased alive on 20 April 1949, and that death occurred at 3:05 P.M., from the causes and on the date stated above.

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|---|--------------------------------|-----------------------------------|
| 23a. SIGNATURE (Degree or title) <u>David Glenn O. MD</u> | 23b. ADDRESS <u>WARSAW, Mo</u> | 23c. DATE SIGNED <u>20 Apr 49</u> |
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|---|---------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>April 22, 1949</u> | 24c. NAME OF CEMETERY, OR CREMATORY <u>CABLE RIDGE</u> | 24d. LOCATION (City, town, or county) (State) <u>WARSAW, Mo</u> |
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| DATE REC'D BY LOCAL REG. <u>22 Apr 1949</u> | REGISTRAR'S SIGNATURE <u>Joe A. Logan</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John F. Reser Warsaw, Mo</u> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 7
District File Number 4-49-499
Date Filed 5-5-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed John F. Reser

Licensed Embalmer No. 4098

P. O. Address Warsaw

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.