

FILED SEP 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26695**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5466** Registrar's No. **793**

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Texas</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Rural South Campbell Twp.</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Hartshorn</b>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>OZARK OSTEOPATHIC HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) <b>William James Hayes</b>		c. (Last) <b>Hayes</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Sept 4-1949</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 1 1876</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>US A</b>	

13a. FATHER'S NAME <b>James Hayes</b>		13b. MOTHER'S MAIDEN NAME <b>Doxie Medlock</b>		14. NAME OF HUSBAND OR WIFE <b>Nellie H. Hayes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Nellie H. Hayes</b> ADDRESS <b>Hartshorn, Mo</b>	

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Circulatory collapse</b>		INTERVAL BETWEEN ONSET AND DEATH  <b>1-10X</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. DUE TO (b) <b>acute myocardial failure</b>		
	DUE TO (c) <b>Prostatism</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>8/23/49</b>		19b. MAJOR FINDINGS OF OPERATION <b>Hypertrophy of Prostate</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR _____	

22. I hereby certify that I attended the deceased from **8/20**, 19**49**, to **9/1**, 19**49**, that I last saw the deceased alive on **9/4/49**, 19**49**, and that death occurred at **5:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>R. A. Michael D.O.</b>		23b. ADDRESS <b>Springfield Mo</b>		23c. DATE SIGNED <b>9/4/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>9-4-1949</b>		24c. NAME OF CEMETERY OR CREMATORY AND LOCATION (City, town, or county) (State) <b>Cedar Grove Cedar Grove, Mo</b>	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>9-7-49 W.E. Handley, MD III</b>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>Gorman-Schaff, Springfield, Mo</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

**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

*Lewis G. Schaff*

Licensed Embalmer No. *3842*

P. O. Address *Springfield,*

**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.