

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **26074**

FILED AUG 28 1950

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **958**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY Buchanan		a. STATE Kansas b. COUNTY Doniphan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Elwood	
c. LENGTH OF STAY (in this place) 1 Mo.		8150	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Methodist Hosp.		d. STREET ADDRESS (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print):	a. (First) Otis	b. (Middle) Shelton	c. (Last) Hayes	4. DATE OF DEATH (Month) (Day) (Year)
				8 17 1950

5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 7 19 1872	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Packing Co.	11. BIRTHPLACE (State or foreign country) Keystone - Mo. 0	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Harrison Hayes	13b. MOTHER'S MAIDEN NAME Rottie Locke	14. NAME OF HUSBAND OR WIFE Ella Mae Hayes
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME William H. Ewing	ADDRESS 1209 No. 13th St
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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 Probably several years. 153X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Coecum		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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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?
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22. I hereby certify that I attended the deceased from 8-10-1950, to 8-17-1950, that I last saw the deceased alive on 8-17-1950, and that death occurred at 6 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Paul Ferguson M.D.	23b. ADDRESS St. Joseph, Mo.	23c. DATE SIGNED 8-19-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8 20 1950	24c. NAME OF CEMETERY OR CREMATORY Belmont Cemetery	24d. LOCATION (City, town, or county) (State) Wathena Kansas
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DATE REC'D BY LOCAL REG. Aug. 25 1950	REGISTRAR'S SIGNATURE E. G. Jenkins	382	25. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Alexander	ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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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 Wm. H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph, 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.