

No. 300
10. 48

NOV 30 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36262
Registrar's No. 89

BIRTH NO. 74317-51 REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 4009

1. PLACE OF DEATH
a. COUNTY Andrew
b. CITY OR TOWN Savannah
d. FULL NAME OF HOSPITAL OR INSTITUTION 505 N. Henry

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Missouri b. COUNTY Andrew
c. CITY OR TOWN Savannah
d. STREET ADDRESS 505 N. Henry

3. NAME OF DECEASED (Type or Print)
a. (First) (Baby) b. (Middle) Hayward c. (Last) Hayward
4. DATE OF DEATH (Month) (Day) (Year) 11 22 51

5. SEX 6. COLOR OR RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Amorphodite White Never Married
8. DATE OF BIRTH 11-22-51
9. AGE (In years last birthday) 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. 5 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME C.E. Hayward
13b. MOTHER'S MAIDEN NAME
14. NAME OF HUSBAND OR WIFE None

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 ADDRESS C.E. Hayward Savannah

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, asthma, etc. It means the disease, injury, or complication which caused death.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory failure
ANTECEDENT CAUSES Incomplete respiratory cerebral center development
Morbidity 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 Absence of anus, rectum, urethra, definite male or female genitalia.
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 7-593
20. AUTOPSY? YES NO

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)
21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 22, 1951, to Nov. 22, 1951, that I last saw the deceased alive on Nov. 22, 1951, and that death occurred at 11:08 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W.B. Maxwell, D.O.
23b. ADDRESS 307 W. Main, Savannah Mo.
23c. DATE SIGNED 11/24/51

24a. BURIAL, CREMATION, REMOVAL (Specify) 11-24-51
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY Savannah City
24d. LOCATION (City, town, or county) (State) Savannah Mo.

DATE REC'D BY LOCAL REG. 11-24-51
REGISTRAR'S SIGNATURE Lillian Spair
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. C. Reid Savannah Mo.

(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 _____

Licensed Embalmer No. 4778

P. O. Address Savannah, 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.