

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44954**

FILED JAN 8 1954

BIRTH NO. _____ REG. DIST. NO. 365 PRIMARY REG. DIST. NO. 6238 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Washington</u>	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Rural Belgrade</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Belgrade</u> <u>1100</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ALICE</u>	b. (Middle) <u>IZELLA</u>	c. (Last) <u>HAYS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 27, 1953</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, <u>WIDOWED</u> , DIVORCED (Specify)	8. DATE OF BIRTH <u>April-19-1862</u>	9. AGE (In years last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u>	IF UNDER 2 HRS. Hours <u>0</u> 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	11. BIRTHPLACE (State or foreign country) <u>Belgrade, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Silas Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Yates</u>	14. NAME OF HUSBAND OR WIFE <u>Albert Jackson Hays</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</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Frank Hays</u> ADDRESS <u>Belgrade, Mo</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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Apoplexy</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>		
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 type="checkbox"/> NO <input checked="" type="checkbox"/> <u>334X</u>
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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) (Min.)	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 June 2, 1953 to Dec 27, 1953, that I last saw the deceased alive on 12-20, 1953, and that death occurred at 5:56A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Joseph L. Thurman, M.D.</u> (Degree or title)	23b. ADDRESS <u>Potosi, Missouri</u>	23c. DATE SIGNED <u>12-29-53</u>
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24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec-29-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Ceme</u>	24d. LOCATION (City, town, or county) (State) <u>Caledonia, Mo</u>
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DATE REC'D BY LOCAL REG. <u>1-2-54</u>	REGISTRAR'S SIGNATURE <u>Ella D. White</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>SPARKS F. HOME</u> ADDRESS <u>Flat River, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
JAN 7 1953
WASH. COUNTY HEALTH DEPT.
File No. _____

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 *Murphy L. Spence* _____

Licensed Embalmer No. *4236* _____

P. O. Address *Flat River, 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.