

FILED AUG 20 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26407

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO: 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 428

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Butler</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff, Mo.</u>		c. CITY OR TOWN <u>Poplar Bluff</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>None 721 North 10th St.</u>		STREET ADDRESS (If rural, give location) <u>721 North 10th</u> <u>0128</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>T.</u> c. (Last) <u>Hays</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 29, 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 9, 1868</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>7</u>	IF UNDER 24 HRS. Days <u>20</u> Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Mt. Vernon, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Sam Hays</u>	13b. MOTHER'S MAIDEN NAME <u>Jennie Burton</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</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. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME <u>Alvie Hays, Poplar Bluff, Mo.</u>	ADDRESS _____
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>10 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>Cerebral Arteriosclerosis</u> 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 <u>331 X</u>	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) _____
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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 July 23, 1954, to July 29, 1954, that I last saw the deceased alive on July 31, 1954, and that death occurred at 6:45 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Marvin L. Barbour, M.D.</u>	(Degree or title) _____	23b. ADDRESS <u>Poplar Bluff, Mo.</u>	23c. DATE SIGNED <u>8/6/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-1-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Black Creek Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Poplar Bluff, Mo. Rural</u>
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DATE REC'D BY LOCAL REG. <u>8/10/54</u>	REGISTRAR'S SIGNATURE <u>R.H. Muehle</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Cotrell</u>	ADDRESS <u>Funeral Chapel, Poplar Bluff, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

124

RECEIVED  
AUG 16 1954

BUTLER CO. HEALTH CENTER

FILE NO. \_\_\_\_\_

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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 \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 296

P. O. Address \_\_\_\_\_

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.