

FILED DEC 1 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 37976

BIRTH NO. _____		REG. DIST. NO. <u>200</u>		PRIMARY REG. DIST. NO. <u>3041</u>		Registrar's No. <u>10</u>	
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Macon</u>		c. LENGTH OF STAY (in this place) <u>1 day</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Macon</u>		d. STREET ADDRESS (If rural, give location) <u>200 1/2 Vine Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Samaritan Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>200 1/2 Vine Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charley</u> b. (Middle) <u>Mo-rison</u> c. (Last) <u>Lay</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 7, 1954</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 20, 1886</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>coal miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>coal mining</u>		11. BIRTHPLACE (State or foreign country) <u>Troy, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Crasmus Lay</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Tumlin</u>		14. NAME OF HUSBAND OR WIFE <u>Georgie Ann Lay</u>			
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>491-07-2409</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Georgie Lay, Macon, Mo.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>332X</u>	
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) _____		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 <u>Nov 2, 1954</u> , to <u>Nov 7, 1954</u> , that I last saw the deceased alive on <u>Nov. 7, 1954</u> , and that death occurred at <u>2 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>P. C. Madson M.D.</u>				23b. ADDRESS <u>Macon, Mo.</u>		23c. DATE SIGNED <u>11/9/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Nov. 9, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>College Mound</u>		24d. LOCATION (City, town, or county) (State) <u>College Mound, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>11/22/54</u>		REGISTRAR'S SIGNATURE <u>Ruth M. Sweeney</u>		185 F. FUNERAL DIRECTOR'S SIGNATURE <u>R. T. Fisher</u>		ADDRESS <u>Bran Macon, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

DEC 2

RECEIVED
MACON COUNTY HEALTH DEPARTMENT
County File No. 11-54-188
Date Filed 11.30.54

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.

Signed Howard Smyers

Signed _____
Student Embalmer

Licensed Embalmer No. 4497

P. O. Address Macon 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.