

FILED DEC 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **40151**

BIRTH NO. _____		REG. DIST. NO. 113		PRIMARY REG. DIST. NO. 5431		Registrar's No. 549			
1. PLACE OF DEATH a. COUNTY Franklin				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Franklin					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Prairie		c. LENGTH OF STAY (in this place) 55 yrs		c. CITY OR TOWN Lonedell		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Lonedell Route				STREET ADDRESS (If rural, give location) Lonedell Route 0360					
3. NAME OF DECEASED (Type or Print) Mary			a. (First)		b. (Middle) Hayhurst		c. (Last)		
4. DATE OF DEATH Dec. 10, 1955		(Month) (Day) (Year)		5. SEX Female		6. COLOR OR RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Dec. 26, 1876		9. AGE (In years last birthday) 78		IF UNDER 1 YEAR: Months _____ Days _____			
IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Missouri			
12. COUNTRY OF WHAT CITIZENRY? USA		13a. FATHER'S NAME Henry Hammer		13b. MOTHER'S MAIDEN NAME Sally Omohondro		14. NAME OF HUSBAND OR WIFE Edwin Hayhurst			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Virginia Steinrauf		ADDRESS St. Clair, Mo			
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	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage				-				78 hr	
ANTECEDENT CAUSES				DUE TO (b) Arteriosclerosis				10 yr	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (c) Malignant Hypertension				4-5 yr	
II. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death. 331X					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <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 _____, 19 51 , to Death 19____, that I last saw the deceased alive on 12-10 , 19 55 , and that death occurred at 11:35 p. m., from the causes and on the date stated above.									
23a. SIGNATURE John J. Paul, MD (Degree or title)				23b. ADDRESS St. Clair, Mo			23c. DATE SIGNED 12-11-55		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 12-13-55		24c. NAME OF CEMETERY OR CREMATORY Pacific City Cemetery		24d. LOCATION (City, town, or county) (State) Pacific, Mo.			
DATE REC'D BY LOCAL REG. 12-13-55		REGISTRAR'S SIGNATURE Floyd Williams 571-0		25. FUNERAL DIRECTOR'S SIGNATURE Casey & Lenox		ADDRESS St. Clair, 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.....
Signature of Student Embalmer

Signed *H. M. Lewis*.....

Licensed Embalmer No. *3600*
P. O. Address *St. Cloud*

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.