

FILED MAR 12 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4492

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 133 PRIMARY REG. DIST. NO. 5499 Registrar's No. 46

1. PLACE OF DEATH a. COUNTY Harrison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) + a. STATE Missouri b. COUNTY Worth	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Lincoln Twp. 8 Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sheridan 11301	
d. FULL NAME OF HOSPITAL OR INSTITUTION John Clark Home		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Clyde b. (Middle) Chancy c. (Last) Hays			4. DATE OF DEATH (Month) (Day) (Year) Feb. 15 1956			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 14 1878	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months 8 Days 1	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? 1

13a. FATHER'S NAME Andrew Hays	13b. MOTHER'S MAIDEN NAME Isabelle Kauble	14. NAME OF HUSBAND OR WIFE Mignon Hays
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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) No	16. SOCIAL SECURITY NO. ✓	17. INFORMANT'S SIGNATURE OR NAME Grace B. Bales Athelstan Ia.	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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate		INTERVAL BETWEEN ONSET AND DEATH 3yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last.		
	DUE TO (c) Paralysis Agitans 177x Arteriosclerosis with Hypertension 5yrs		5yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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 \_\_\_\_\_, 19 50, to Feb 15, 19 56, that I last saw the deceased alive on Feb 12, 1956, and that death occurred at 5 a. m., from the causes and on the date stated above.

23a. SIGNATURE Frank B. Mattison MD (Degree or title)	23b. ADDRESS Grant City, Missouri	23c. DATE SIGNED 2-15-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Feb. 15 1956	24c. NAME OF CEMETERY OR CREMATORY Athelstan Cemetery	24d. LOCATION (City, town, or county) (State) Athelstan Iowa
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DATE REC'D BY LOCAL REG. 2-23-56	REGISTRAR'S SIGNATURE Zola Burris	25. FUNERAL DIRECTOR'S SIGNATURE Floyd Edmund Bedford Iowa	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

3-7-56

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 \_\_\_\_\_

MYSELF

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Floyd E. Shuman

Licensed Embalmer No. 2381 Iowa

P. O. Address Bedford Iowa

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.