

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12790

STATE FILE NUMBER

FILED MAY 14 1957

Registration District No. 128 Primary Registration District No. 2070 Registrar's No. 429

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Dallas</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rural - Lincoln</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SPFC. Baptist Hosp.</u>				Length of stay in lb <u>11 days</u>		d. STREET ADDRESS (If outside, give location) Reside <input checked="" type="checkbox"/> Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Francis</u> Last <u>Hayes</u>				4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug-22-1880</u>	
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>11</u> Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (City and state or country) <u>Hickory Co, MO</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Amos F. Hayes</u>				14. MOTHER'S MAIDEN NAME <u>Susie E. Scott.</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>490,28-2606</u>		17. INFORMANT Address <u>MRS. Nancy Hayes, Urbana, MO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Benign Prostatic Hypertrophy</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u>  <u>5-6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>610x</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		CITY _____ STATE _____	
21. I attended the deceased from <u>4.15.57</u> to <u>5.3.57</u> and last saw <del>her</del> <u>him</u> alive on <u>5.3.57</u> Death occurred at <u>12:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Print or Title) <u>William F. Johnson, M.D.</u>				22b. ADDRESS <u>211 Professional Building Springfield, Missouri</u>			22c. DATE SIGNED <u>5-6-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-5-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Olive Point Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Hickory Co MO.</u>		
24. FUNERAL DIRECTOR <u>Allen W. Vaughan</u>			ADDRESS <u>Urbana, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>5-13-57</u>		26. REGISTRAR'S SIGNATURE <u>Faith Williamson</u>

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

S. 300  
Y. 1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Allen W. Saugbar*

Licensed Embalmer No. *415*

P. O. Address *Urban*

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.