

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 0 2 3 3 5 5
State File No.

FILED JUN 19 1957

BIRTH NO.		REG. DIST. NO. <u>374</u>		PRIMARY REG. DIST. NO. <u>4547</u>		Registrar's No. <u>23</u>	
1. PLACE OF DEATH a. COUNTY <u>WORTH</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WORTH</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Grant City mo</u>		c. LENGTH OF STAY (in this place) <u>3 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL ALLEN TWP</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Grant City Nursing Home</u>				d. STREET ADDRESS (If rural, give location) <u>1130</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u>		b. (Middle) <u>SATE</u>		c. (Last) <u>HAYNER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 4 1957</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, <u>WIDOWED</u> WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>May 25-1877</u>	
9. AGE (In years last birthday) <u>80</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) / <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Joseph Hayner</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Anderson</u>		14. NAME OF HUSBAND OR WIFE <u>Elorence Elsie Hayner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Carl Hayner</u>		ADDRESS <u>Grant City 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>MEDULLARY FAILURE</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>THROMBUS EMBOLISM</u> DUE TO (c) <u>ATRICULAR FIBRILLATION</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>HYPOSTATIC PNEUMONIA</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <u>2</u> YES ☐ NO ☒			
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) m.		21e. INJURY OCCURRED WHILE AT ☐ WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT.</u> , 19 <u>56</u> , to <u>JUNE 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUNE 4</u> , 19 <u>57</u> , and that death occurred at <u>8:25 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Richard C. Swift D.O.</u>				23b. ADDRESS <u>GRANT CITY MO.</u>		23c. DATE SIGNED <u>6-8-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 5-1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Miller Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Warner MO</u>	
DATE REC'D BY LOCAL REG. <u>6-10-1957</u>		REGISTRAR'S SIGNATURE <u>Leta E. Dawson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>KA Hume</u>		ADDRESS <u>Warner Mo</u>	

(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 _____

John Andrews

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John Andrews

Licensed Embalmer No. *4211*

P. O. Address *Grant City 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.