

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024728
STATE FILE NUMBER

RN 16749
XC-Unknown
Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 258
FILED JUL 27 1958

5. 300
1-57

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dunklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Poplar Bluff		c. CITY OR TOWN Clarkton	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital		d. STREET ADDRESS (If outside, give location) Box 111	
Length of stay in 1b 2 days		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First John Middle (none) Last Hayes			4. DATE OF DEATH Month July Day 10 Year 1958		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-93	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Bernie, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Hayes	13b. MOTHER'S MAIDEN NAME Porthania Blades	14. NAME OF HUSBAND OR WIFE Pauline Watson Hayes
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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) Yes WVI	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT VA Hospital Records	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart Disease, due to arteriosclerosis of coronary arteries. a. Generalized cardiac enlargement. DUE TO (b) Bundle Branch Block, unspecified. c. Decompensated Class IV DUE TO (c) 4201		INTERVAL BETWEEN ONSET AND DEATH 9 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary emphysema, senile, severe; Arteriosclerosis generalized,		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Give nature of injury in PART I or PART II of item 18.) None
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION VAH, POPLAR BLUFF, MO.	COUNTY	STATE
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21. I attended the deceased from July 8, 1958 to July 10, 1958 Death occurred at 10:50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE Robert S. Cohen ROBERT S. COHEN, M.D., Chf Med Sv.,	22b. ADDRESS VAH, POPLAR BLUFF, MO.	22c. DATE SIGNED 7/11/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 13, 1958	23c. NAME OF CEMETERY OR CREMATORY Bernie Cemetery	23d. LOCATION (City, town, or county) (State) Bernie, Missouri
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24. FUNERAL DIRECTOR Landess Funeral Home, Campbell, Mo.	25. DATE RECD. BY LOCAL REG. 7/19/58	26. REGISTRAR'S SIGNATURE R. Mueller
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

890
110

8561 8 4 1958

STATE OF OHIO
DEPARTMENT OF HEALTH

RECEIVED

JUL 21 1958

BUTLER CO. HEALTH CENTER

SEP 18 1958

FILE No. _____

Name of Deceased _____
 Date of Death _____
 Place of Death _____
 Cause of Death _____
 Age at Death _____
 Sex _____
 Race _____
 Marital Status _____
 Occupation _____
 Education _____
 Religion _____
 Social Security No. _____
 Birth Date _____
 Birth Place _____
 Death Date _____
 Death Place _____
 Burial Date _____
 Burial Place _____
 Name of Undertaker _____
 Address of Undertaker _____
 City _____ State _____ Zip _____

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 *Christine M. Landess*

Licensed Embalmer No. *4227*
P. O. Address *Campbell, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.