

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033363  
STATE FILE NUMBER

FILED OCT 3 1958 Registration District No. 174 Primary Registration District No. 5644 Registrar's No. 75

S. 300  
1-57  
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1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clay Twns Lexington</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Odessa</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Goodloe Nurseing Home</b>		Length of stay in 1b <b>5 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>4 Block S. 40th</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Hamma</b> Middle <b>Hayes</b> Last <b>Hayes</b>			4. DATE OF DEATH Month <b>September</b> Day <b>11</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3, 1863</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years of birthday) <b>95</b> 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) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Tennessee</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>John Hayes</b>	13b. MOTHER'S MAIDEN NAME <b>Polly M. Ogan</b>
14. NAME OF HUSBAND OR WIFE <b>None</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>
17. INFORMANT <b>Mrs. Husha Smith, Portalis, N.M.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Degeneration - 2 1/2 hrs</b> DUE TO (b) <b>Plate Coronary Thrombosis - 4201</b> DUE TO (c) <b>Chronic Hypertension - 20 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Patient had Chronic Hypertension with 1st pr. grad.</b>			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. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		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 COUNTY _____ STATE _____	
21. I attended the deceased from Death occurred at <b>July 14, 1958</b> and last saw her/him alive on <b>Sept. 4, 1958</b> , on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John C. Bellon D.O.</b>		22b. ADDRESS <b>1110 1/2 W. Main St. Lee, Mo.</b>	
22c. DATE SIGNED <b>9/12/58</b>		22d. DATE RECD. BY LOCAL REG. <b>9-22-58</b>	
23a. BURIAL, CREMATION, OR OTHER DISPOSITION <b>Burial</b>		23b. DATE <b>Sept. 14, 1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Odessa Cemetery</b>		23d. LOCATION (City, town, or county) <b>Odessa, Mo.</b>	
24. FUNERAL DIRECTOR <b>Husman-Sparks</b>		26. REGISTRAR'S SIGNATURE <b>Anna E. Sautter</b>	
ADDRESS <b>Odessa, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-22-58</b>	

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

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 *William T. Sparks* .....

Licensed Embalmer No. *14431* .....  
P. O. Address *Odessa* .....

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.