

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038664

FILED VS NOV 9 1959

STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 110

ENDED

1. PLACE OF DEATH a. COUNTY <b>Sullivan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Sullivan</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Milan</b>		Length of stay in 1b <b>1 Wk.</b>		c. CITY OR TOWN <b>Harris</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>S. C. M. Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Zillah</b> Middle <b>Hayes</b> Last <b>Hayes</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>29</b> Year <b>1959</b>						
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10-7-1885</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			
13a. FATHER'S NAME <b>John Hill</b>			13b. MOTHER'S MAIDEN NAME <b>Christine Cox</b>			14. NAME OF HUSBAND OR WIFE <b>Alfred Hayes</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs Hugh Morehead Jr. Milan Mo.</b>					
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>broncho pneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3da</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Chronic myocarditis</b>						<b>5 yrs</b>		
		DUE TO (c) <b>fracture of left femur</b>						<b>10/16/59</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>fell in home</b>								
20c. TIME OF INJURY Hour <b>6:00</b> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	Month, Day, Year <b>10-16-59</b>									
20d. INJURY OCCURRED WHILE AT WORK <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.) <b>HOME</b>		20f. CITY, TOWN, OR LOCATION <b>HARRIS</b>	COUNTY <b>SULLIVAN</b>		STATE <b>MO</b>			
21. I attended the deceased from <b>10/11/59</b> to <b>10/29/59</b> and last saw her/him alive on <b>10/29/59</b> Death occurred at _____ p.m. on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <b>W. Wise M.D.</b>				22b. ADDRESS <b>Harris, Mo</b>				22c. DATE SIGNED <b>10/30/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-1-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Grove Cem.</b>		23d. LOCATION (City, town, or county) <b>Osgood Mo.</b>						
24. FUNERAL DIRECTOR ADDRESS <b>Judd &amp; Payne Newton Mo</b>			25. DATE RECD. BY LOCAL REG. <b>11-2-59</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. M. W. Beckett</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 PK Payne Jr

Licensed Embalmer No. 3400

P. O. Address Laet

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.