

VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1960

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=60-033887

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Holt	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph	Length of stay in 1b 6 weeks	c. CITY OR TOWN Oregon (Rural) Lewis Twp.	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hospt.		d. STREET ADDRESS (If outside, give location) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH
First Oren Middle Wesley Last Hayes	Month September Day 21, Year 1960

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 4/8/1888	9. AGE (last birthday) 72 years	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR 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	11. BIRTHPLACE (City and state or country) Holt Co. Missouri	12. CITIZEN OF WHAT COUNTRY U. S.
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13a. FATHER'S NAME Alvin Howard Hayes	13b. MOTHER'S MAIDEN NAME Minnie L. Stroud	14. NAME OF HUSBAND OR WIFE Jennie Maye 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) No	16. SOCIAL SECURITY NO. 494-40-7595	17. INFORMANT Address Mrs. Oren Hayes Oregon, Missouri
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Coronary Thrombosis		10 wks.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Coronary Insufficiency	12 wks?
	DUE TO (c) Coronary Atherosclerosis	?

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
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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.)
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20c. TIME OF INJURY	Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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
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21. I attended the deceased from Aug - 15 - 60 to Sept - 21 - 60 and last saw ^{her}him alive on Sept - 21 - 60
 Death occurred at 6:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>T. L. Howden M.D.</i>	22b. ADDRESS 419 North Central Ave.	22c. DATE SIGNED Sept 24
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23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE 9/25/60	23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery	23d. LOCATION (City, town, or county) (State) Mount City, Missouri
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24. FUNERAL DIRECTOR ADDRESS <i>W. A. Smith, Pittsburg, Oregon Mo.</i>	25. DATE RECD. BY LOCAL REG. Sept. 24, 1960	26. REGISTRAR'S SIGNATURE <i>Mr. Clark Handell</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

T. L. Howden, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 3 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James H. Pettigrew

Licensed Embalmer No. 3192

P. O. Address Oregon, 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.