

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035539

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 170

AMENDED

FILED OCT 2 1961

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

BY AFFIDAVIT OF MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Length of stay in 1b <b>4 Hrs.</b>	c. CITY OR TOWN <b>Gilliam</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fitzgibbon Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>10 Mi SE Gilliam</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>(NONE)</b> Last <b>HAY</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>26</b> Year <b>1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/31/1872</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	9. AGE (last birthday) <b>89</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>Longwood, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Peter Hay</b>		13b. MOTHER'S MAIDEN NAME <b>Lucretia McCleary</b>	
14. NAME OF HUSBAND OR WIFE <b>Minnie Hay</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>Don't Know</b>		17. INFORMANT <b>Leander Hay Gilliam, 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>Cardiac failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chr. Myocarditis</b> DUE TO (c) <b>Chr. Nephritis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>17 hrs</b> <b>10 years</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized arteriosclerosis</b>			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.)	
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 checked="" 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 <b>1944</b> to <b>Sept. 26, 1961</b> and last saw him alive on <b>Sept. 26, 1961</b> (Death occurred at <b>9 P</b> m on the date stated above, and to the best of my knowledge from the causes stated.)			
22a. SIGNATURE (Degree or title) <b>C. C. McBurney, M.D.</b>		22b. ADDRESS <b>Slater, Mo.</b>	22c. DATE SIGNED <b>9-27-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Sept. 29, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Slater</b>	23d. LOCATION (City, town, or county) (State) <b>Slater, Missouri</b>
24. FUNERAL DIRECTOR <b>Haines Funeral Home Slater, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>9-29-61</b>	26. REGISTRAR'S SIGNATURE <b>Cecil G. Read</b>

NOV 7 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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Walter J. Haines, Jr.

Licensed Embalmer No. 4557

P. O. Address Slater, 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.