

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-014322
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 15 1962 Primary Registration District No. 3007 Registrar's No. 749

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fisk		Length of stay in 1b 2 years	c. CITY OR TOWN Fisk Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (if outside, give location) RFD #1 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle MARSHALL Last HAYES		4. DATE OF DEATH Month May Day 3 Year 1962	
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 4-15-1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11a. FATHER'S NAME Charles P. Hayes		11b. MOTHER'S MAIDEN NAME Sarah Keen	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		12b. SOCIAL SECURITY NO. unknown	
13a. FATHER'S NAME Charles P. Hayes		13b. MOTHER'S MAIDEN NAME Sarah Keen	
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		14b. SOCIAL SECURITY NO. unknown	
15. FATHER'S NAME Charles P. Hayes		15. MOTHER'S MAIDEN NAME Sarah Keen	
16. 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. unknown	
17. FATHER'S NAME Charles P. Hayes		17. MOTHER'S MAIDEN NAME Sarah Keen	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage DUE TO (c) Hypertension & Cardiac failure		18. INTERVAL BETWEEN ONSET AND DEATH	
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 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		20g. COUNTY	
20h. STATE		20i. DATE OF DEATH	
21. I attended the deceased from 2-6-62 to 5-3-62 and last saw him alive on 5-3-62 Death occurred at 2:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		21. DATE OF DEATH	
22a. SIGNATURE L. Peterson D.O. (Degree or title)		22b. ADDRESS 204 Baletts St Poplar Bluff	
22c. DATE SIGNED 5-8-62		22d. COUNTY	
22e. STATE		22f. CITY, TOWN, OR LOCATION	
22g. COUNTY		22h. STATE	
22i. DATE OF DEATH		22j. TIME OF DEATH	
22k. PLACE OF DEATH		22l. CAUSE OF DEATH	
22m. USUAL RESIDENCE		22n. MANNER OF DEATH	
22o. NAME OF DECEASED		22p. DATE OF DEATH	
22q. COUNTY		22r. STATE	
22s. CITY, TOWN, OR LOCATION		22t. ADDRESS	
22u. DATE OF DEATH		22v. TIME OF DEATH	
22w. PLACE OF DEATH		22x. CAUSE OF DEATH	
22y. USUAL RESIDENCE		22z. MANNER OF DEATH	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 5, 1962	
23c. NAME OF CEMETERY OR CREMATORY Mole Hill Cemetery		23d. LOCATION (City, town, or county) (State) Broseley (rural) Missouri	
24. FUNERAL DIRECTOR Landess Funeral Home, Campbell, Mo.		25. DATE RECD. BY LOCAL REG. 5/10/1962	
26. REGISTRAR'S SIGNATURE Thelma Graham		27. COUNTY	
28. STATE		29. CITY, TOWN, OR LOCATION	
30. ADDRESS		31. DATE OF DEATH	
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MAY 17 1962

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

Richard V. Beall

Licensed Embalmer No. 5116

P. O. Address Malden, 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.