

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 114 Sherman (Convalescent Home)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution almost 1 year
(Specify whether years, months or days)
In this community 17 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58
(c) City or town Brookfield 1
(If outside city or town limits, write "RURAL")
(d) Street No. 114 Sherman 2
(If rural, give location)
(e) Citizen of foreign country? No 0
(Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charley Gayman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 1 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 17 1866
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 14 If less than one day hr. _____ min. _____

9. Birthplace New Cambria Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farm Hand

MOTHER FATHER

11. Industry or business _____
12. Name Lois Gayman
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Margaret (Unknown)
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Rose Frasier
(b) Address Brookfield Mo

17. (a) Burial (b) Date thereof May 2, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Cambria, Missouri

18. (a) Signature of funeral director Hill Funeral Home

(b) Address Brookfield, Missouri

19. (a) May 2, 1946 (b) Evelyn Kelley, Deputy
(Date reported to local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1
year 1946 hour 15 minute 15 p M.

21. I hereby certify that I attended the deceased from Apr 25
1946 to April 30 1946
that I last saw him alive on April 30 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration 4 days

Due to Coronary Artery Disease
liver and abdominal issues years? _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED PHYSICIAN _____
Of autopsy _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature D. W. Dean (M. D. or other) MD
Address Brookfield Date signed 5/2/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. H. Blacklock

Licensed Embalmer No. 2246

P. O. Address. Brookfield 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 this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June

Registrar's No. 50

Registration District No. 184

Primary Registration District No. 0038

1. PLACE OF DEATH:

(a) County Lin
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME

Charley Hayman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 17 1878
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Myocardial Insufficiency 4 days

Due to Carcinoma of Liver 2 yrs

Due to (primary)

Other conditions Accidental
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M.D. or other) MD

Address Brookfield Mo Date signed 6/18/46

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

16148

17267