

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035674**

**FILED VS. OCT 20 1959 99**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **45**

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>DeKalb</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>DeKalb</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Union Star</b>		c. CITY OR TOWN <b>Union Star</b>	
Length of stay in lb <b>Lifetime</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		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Myra</b> Middle <b>-</b> Last <b>Hayes</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>13,</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>2/14/75</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months _____ Days _____
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 <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>- Indiana</b>	
12. CITIZEN OF WHAT COUNTRY <b>US</b>		13a. FATHER'S NAME <b>Aaron Price</b>		13b. MOTHER'S MAIDEN NAME <b>Jane Hite</b>	
14. NAME OF HUSBAND OR WIFE <b>Craft Hayes</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Ray Hayes</b>		Address <b>Union Star, 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>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 minute</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis &amp; Hypertension</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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

21. I attended the deceased from **Jan 1955** to **Oct 13, 1959** and last saw her him alive on **Oct 13, 1959**  
 Death occurred at **8:20 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Dr Zacka Barnes DO</b>	(Deceased or title)	22b. ADDRESS <b>King City MO</b>	22c. DATE SIGNED <b>10-14-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 15, 59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Star</b>	23d. LOCATION (City, town, or county) (State) <b>Union Star, Missouri</b>

24. FUNERAL DIRECTOR <b>Roland D Black</b>	ADDRESS <b>King City MO 10-17-59</b>	25. DATE RECD. BY LOCAL REG. <b>10-17-59</b>	26. REGISTRAR'S SIGNATURE <b>Kenneth D. ...</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

*Roland W. Clark*

Licensed Embalmer No.

*4477*

P. O. Address

*King City*

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.