

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

19536

1. PLACE OF DEATH

County... **Jackson** Registration District No. **399**
Township... **Kaw** Primary Registration District No. **1002**
City... **Kansas City** (No. **K.C. General Hospital**)

File No. **F. 2536**
Registered No. **2536**
St. _____ Ward _____

2. FULL NAME **Chris Hayden**

(a) Residence. No. **Not known** St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not Known				
7. AGE About 50	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Painter (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

10. NAME OF FATHER **Not known**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

12. MAIDEN NAME OF MOTHER **Not known**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

14. INFORMANT **Record Clerk**
(Address) **K.C. General Hospital**

15. FILED **1/18 1930** **M.M. Cronin** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6-13 1930**

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Alakism

CONTRIBUTORY (SECONDARY) **66B** (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS **Autopsy**

(Signed) **Stanley W. Steel** M. D.
1/13 1930 (Address) **Deputy Coroner**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Maple Hill Cemetary** DATE OF BURIAL **6-18-30**

20. UNDERTAKER **P. Louis, Funeral Director** ADDRESS **City, Mo**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

