

NOV 2 1938

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

34927
Do not use this space.

1. PLACE OF DEATH

(a) County Garrison Registration District No. 399

(b) Township Kan Primary Registration District No. 1002

(c) City Kansas City (d) Street No. 2 C Gen Hosp Registered No. 4263

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Haynes Henry Wirt

(a) Residence, No. 929 1/2 West St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Bessie Haynes

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-13-1859

7. AGE YEARS 81 MONTHS 11 DAYS 18 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Platte City Mo.

FATHER 13. NAME John Haynes

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

MOTHER 15. MAIDEN NAME Sucunda Wirt

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

17. INFORMANT (ADDRESS) Reina Clark 2 C Gen Hosp Kansas City

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE Nov 2 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. M. Brown

20. FILED 11-1-1938 W. M. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-31 1938

22. I HEREBY CERTIFY, That I attended deceased from 10-30 1938 to 10-31 1938

I last saw him alive on 10-31 1938 Death is said to have occurred on the date stated above, at 9:12 a.m.

The principal cause of death and related causes of importance were as follows:

Perforated gall bladder, Cholecystitis and Cholelithiasis

Other contributory causes of importance: Generalized Peritonitis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) P. De Maria, M. D.

(Address) 2 C Gen Hosp Kansas City

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.

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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, above space should be left blank.