

REC'D AUG 7 1939

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

24803  
 Do not use this space.  
 3016

**1. PLACE OF DEATH**

(a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. 1115 E. 59th Street St.  
 (e) Length of residence in city or town where death occurred 53 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Frank G. Hayward

(a) Residence, No. 1115 E. 59th Street St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Married</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Mrs. Rose A. Hayward</b>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>Sept. 7, 1857</b>		
7. AGE	YEARS <b>81</b>	MONTHS <b>10</b>
	DAYS <b>19</b>	IF LESS than 1 day, .....hrs. or .....min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <b>Retired</b>	
	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) <b>Ohio</b>		
FATHER	13. NAME <b>Martin Hayward</b>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>New York</b>	
MOTHER	15. MAIDEN NAME <b>Cornelia Todd</b>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Ohio</b>	
17. INFORMANT <b>Mrs. Rose A. Hayward</b> (ADDRESS) <b>1115 E. 59th Street</b>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Mt. Moriah</b> DATE <b>July 28, 1939</b>		
19. FUNERAL DIRECTOR (NAME) <b>Freeman Mortuary</b> (ADDRESS) <b>104 W. 42nd St., K.C., Mo.</b>		
20. FILED <b>July 27, 1939 M. M. Browne</b> Local Registrar.		

**MEDICAL CERTIFICATE OF DEATH**21. DATE OF DEATH (MONTH, DAY, AND YEAR) **July 26, 1939**

22. I HEREBY CERTIFY, That I attended deceased from July 16, 1939 to July 26, 1939  
 last seen alive on July 29, 1939. Death is said to have occurred on the date stated above, at 9 A.M.  
 The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage

Date of onset

July 16, 39

Other contributory causes of importance:

Arterio Sclerosis1920

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? No 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) E. W. Shushur, M. D.(Address) 806 Riata Bldg. K.C. 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.....

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.**

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