

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.

12 1940

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town **St. Louis**
 (c) Name of hospital or institution:
6712 Michigan ave.
 (d) Length of stay: In hospital or institution _____
 In this community **Life**
 years, months or days

3. (a) PRINT FULL NAME **Kennerly Haines**
 3. (b) If veteran, name war **None**
 3. (c) Social Security No. **520 None**
 4. Sex **Male**
 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **July 3 1880**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	59	4	27	hr. _____ min.

9. Birthplace **St. Louis Missouri**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **Retired Chief Clerk**

11. Industry or business _____
 12. Name **Wm. F. Haines**
 13. Birthplace **Buffalo New York**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Abbie Kennerly**
 15. Birthplace **Jeff. Bks. Missouri**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Odice Haines**
 (b) Address **6712 Michigan**
 17. (a) **Burial** (b) Date thereof **Dec. 2, 1939**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation? **Calvary Cemetery**
 18. (a) Signature of funeral director **C. Hoffmeister**
 (b) Address **7814 S. Broadway**
 19. (a) **DEC 1 1939** (b) **J. B. Brudick**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
 (d) Street No. **6712 Michigan ave.**
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Nov** day **30**
 year **1939** hour _____ minute **9** M.
 21. I hereby certify that I attended the deceased from **Oct 25th**, 19**37**, to **Nov 29**, 19**37**
 that I last saw him alive on **Nov 27**, 19**37**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic Hypertension
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) **None**
 Major findings: **5-12-10 mm Phase**
 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? _____
 (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 **Max C. Starkloff** (M. D. or other)
 Address **512 Doran** Date signed **11/30/39**

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..... 2649

P. O. Address..... 732 Zernay

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.