

FILED MAR 11 1940

399

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **5385**  
**610**  
Registrar's No.

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

1. PLACE OF DEATH:

Jackson

(a) County \_\_\_\_\_  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1012 Michigan  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 20 years  
years, months or days)

8. (a) PRINT FULL NAME 500 John Layne

8. (b) If veteran, name war No 8. (c) Social Security No. 495-09-3380

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Gussie Layne 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased November 25, 1891  
(Month) (Day) (Year)

8. AGE: Years 48 Months 2 Days 12 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Higginsville Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Wash man

11. Industry or business Laundry

MOTHER FATHER { 12. Name Aaron Layne

13. Birthplace Texas  
(City, town, or county) (State or foreign country)

14. Maiden name Frances Robinson

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Gussie Layne

(b) Address 1012 Michigan

17. (c) removal (b) Date thereof 2-11-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville, Mo.

18. (a) Signature of funeral director William Brown

(b) Address 1729 Lydia

19. (a) Feb. 9, 1940 (b) M. M. Craue  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1012 Michigan  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 7  
year 1940 hour 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from Jan 18, 1940, to Feb 7, 1940  
that I last saw him alive on Feb 6, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage  
Due to J.B.?  
Due to J.B.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? Yes (Specify type of place) \_\_\_\_\_  
(Specify means of injury)

23. Signature W. J. Brown (M. D. or other) \_\_\_\_\_  
Address 1705 E 12th Date signed Feb 9 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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

*Isaac Jerome Mankov*

Licensed Embalmer No. *3994*

P. O. Address *1120 E. 23rd St.*

**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.**

OK