

FILED MAR 1 - 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5595
Registrar's No. 820

Registration District No. 10399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 years
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Melvin Grant Haines

8. (b) If veteran, name war - 8. (c) Social Security No. 497-10-9596

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

6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased June 4, 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 8 16 hr. min.

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

10. Usual occupation Cook

11. Industry or business

12. Name Homer W. Haines

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

14. Maiden name Elizabeth J. Compton

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

16. (a) Informant's own signature Deane Nelson

(b) Address Richland Center, Wis.

17. (a) Burial (b) Date thereof Feb. 23, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 W. 42nd St., K.C., Mo.

19. (a) Feb. 23, 1940 (b) M. M. Crowe
(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. 220 E. 34th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. - years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 20
year 1940 hour 12 minute 5 A. M.

21. I hereby certify that I attended the deceased from 2-16-40
16 to 2-20, 1940

that I last saw him live on 2-19, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bacterial Pneumonia

Due to Influenza

Due to none

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: 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? (City or town) (County) (State)

(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 J. M. Shepard (M. D. or other)
Address 728 Argyle Bldg Date signed 2-22-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39

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.....

Clarence W. Childs

Licensed Embalmer No.....

3473

P. O. Address.....

Ke. C. M. O.

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.