DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17317

Registration District No. 399 — JUN 17 1940 — Primary Registration District No. 1002 — Registrar's No. 1844

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: K.C. General Hospital No.1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days) In this community 52 Yrs.

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. 2624 Askew (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Adolphus Haines 520

3. (b) If veteran, name war No

3. (c) Social Security No. 487-12-5763

4. Sex Male

5. Color or race Wh.

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Alice Haines

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Nov. 30 (Month) 1859 (Day) (Year)

8. AGE: Years 80 Months 5 Days 1 If less than one day ____ hr. ____ min.

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

10. Usual occupation Engraver Jacards Jewelry

11. Industry or business

FATHER
12. Name Milo Haines
13. Birthplace Unknown (City, town, or county) Pa. (State or foreign country)

MOTHER
14. Maiden name Millie Boggess
15. Birthplace Unknown (City, town, or county) Pa. (State or foreign country)

16. (a) Informant's own signature Grace Malin

(b) Address 3121 Jackson

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-40 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Eylar Funeral Home

(b) Address 1800 Linwood K.C.Mo.

19. (a) May 2, 1940 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st year 1940 hour 1 minute 25 P M.

21. I hereby certify that I attended the deceased from May 1st, 1940, 19__, to May 1st, 1940, 19__; that I last saw him alive on May 1st, 1940, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Strangulated umbilical hernia	
Due to 122a	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy None	

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? 361 (Specify type of place)

While at work? (e) Means of injury

23. Signature P. F. De Mama MD (M.D. or other)

Address Supt. K.C. General Hospital, K.C.Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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. 8-17-39 I X19511

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.