

No. 2
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7-39
X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17628

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2155

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: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 4 days (Specify whether
In this community Over 25 years years, months or days)

3. (a) PRINT FULL NAME. Mrs. Emma Hains 532

3. (b) If veteran, name war. No 3. (c) Social Security No. None

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

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

7. Birth date of deceased. Sept. 16 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 8 9 hr. --- min.

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

10. Usual occupation. At Home

11. Industry or business. 9

12. Name. Michael Cody

13. Birthplace. No Record

14. Maiden name. Delilah Irwin

15. Birthplace. No Record

16. (a) Informant. Mrs. P. C. Chapman

(b) Address. 6344 Agnes St. Mo.

17. (a) Removal (b) Date thereof. May 25-40
(Specify cremation or removal) (Month) (Day) (Year)

(c) Place, burial or disposition. Buried in Bucklin, Mo.

18. (a) Signature of funeral director. J. M. Wagner

(b) Address. Kansas City, Mo.

19. (a) May 26, 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. 500 East 45th St.
(If outside city or town limits, write "RURAL")
(d) Street No. Kansas City (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25
year 1940 hour 9 minute 27 A. M.

21. I hereby certify that I attended the deceased from May 27
1940 to May 25 1940
that I last saw him alive on May 25 1940
and that death occurred on the date and hour stated above.

Immediate cause of death. Cardiac failure - Angina pectoris Duration 3/23/40

Due to Acute Pharyngitis with Hydrops 5/26/40

Due to _____

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy. Acute Pharyngitis with Hydrops of Gall bladder
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? _____ (Specify type of place) (e) Means of injury. 1

23. Signature. J. D. Hall (M. D. or other professional) MD

Address. Professional Date signed. 5/25/40

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

MOTHER FATHER

Cecil R. Matthes

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 *Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address *Kansas City, Mo.*

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.