

AUG 14 1940
Registration District No. 399

Primary Registration District No. 1002

State File No. _____
Registrar's No. _____

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (Specify whether
In this community Over 20 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits write "RURAL")
(d) Street No. 2505 East 10th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

8. (a) PRINT FULL NAME Ira Haynes : 520

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married divorced married

6. (b) Name of husband or wife Rosie Haynes 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased June 7 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 0 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Salesman

11. Industry or business _____

12. Name David Haynes

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

14. Maiden name Adeline Wilson

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

16. (a) Informant Rosie Haynes

(b) Address 2505 E 10th St

17. (a) Buried (b) Date thereof 7-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director F. W. Wagner

(b) Address 311 E. W. Wagner

19. (a) July 8, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6th
year 1940 hour 12 minute 10 A. M.

21. I hereby certify that I attended the deceased from June 27th, 1940, to July 6th, 1940;

that I last saw him alive on July 6th, 1940;

and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to Bronchogenic carcinoma

Due to 47

Other conditions Cardiac hypertrophy and dilatation; diffuse myocardial fibrosis

Major findings: Of operations _____

Of autopsy See above

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) Means of injury 1

23. Signature Dwight R. Thore (M. D. or other)
Supt. K.C. Gen. Hospital, K.C. Mo. Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 A. R. Hauschild

Licensed Embalmer No. 4159

P. O. Address K. C. 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.