DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 14 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24161

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2774

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Raw (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5431 Prospect (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution — (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Jackson

(c) City or town: Raw. (If outside city or town limits, write "RURAL")

(d) Street No. 5431-Prospect Ave. (If rural, give location)

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

3. (a) PRINT FULL NAME: Infant Hazley 240

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: Male

5. Color or race: Colored

6. (a) Single, widowed, married, divorced: Inf

6. (b) Name of husband or wife:

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

7. Birth date of deceased: July (Month) 5 (Day) 1940 (Year)

8. AGE: Years — Months — Days — If less than one day: 15 hr. ____ min.

9. Birthplace: Kansas City (City, town, or county) Mo (State or foreign country)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Frank Hazley

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

MOTHER

14. Maiden name: Mattie Mae Barnes

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

16. (a) Informant's own signature: Sarah Barnes

(b) Address: 5431 Prospect

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 9-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Lee

18. (a) Signature of funeral director: Wm A. Johnson

(b) Address: K.C. Gen Hospt

19. (a) July 10, 1940 (Date received local registrar) (b) M. M. Grove (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 5 year 40 hour 1.45 AM minute ____ M.

21. I hereby certify that I attended the deceased from 7-5-40, 19__, to 7-5-40, 19__; that I last saw him alive on 7-5-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Premature claim (Mall) Premature claim

Due to: 7/5/40. 159

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

Major findings: Of operations: no. no.

Of autopsy: no

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): no.

(b) Date of occurrence: no. no.

(c) Where did injury occur? no. (City or town) no. (County) no. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no. no. no. (Specify type of place)

While at work? no (e) Means of injury: no

23. Signature: Glenn B. Ryan M.D. (M. D. or other)

Address: 1006 W 38 KC Date signed: 7/5/40

(Licensed Embalmer's Statement on Reverse Side)

WHITE PEARLY—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.

X19811

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.