

SEP 22 1940

Registration District No. \_\_\_\_\_

Primary Registration District No. 5892

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Johnson  
(b) City or town Rural Jackson  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days 57 1/2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson  
(c) City or town Rural  
(d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME Nancy Jane Haines  
8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Joseph Haines 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased January 29 1854  
(Month) (Day) (Year)

8. AGE: Years 86 Months 6 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name John S. Temple  
13. Birthplace Unknown  
14. Maiden name Marcella Brown  
15. Birthplace Tenn.

16. (a) Informant B. J. Haines  
(b) Address Lees Summit Mo

17. (a) Burial (b) Date thereof Aug 20-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Home Jack Cemetery

18. (a) Signature of funeral director T. M. Goodman  
(b) Address Holden Mo

19. (a) Aug 20, 1940 (b) Mrs. G. P. Redford  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 19  
year 1940 hour 5:00 minute PM  
21. I hereby certify that I attended the deceased from August 19  
1940, 19\_\_\_\_, to Aug 19, 19\_\_\_\_  
that I last saw her alive on Aug 19, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Due to Arteriosclerosis & Hypertension  
Due to \_\_\_\_\_  
Other conditions g. w.  
(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 Kelly Rawlins (M. D. or other) \_\_\_\_\_  
Address Holden Mo Date signed 8/19/40

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 9-13-40

**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 *J. P. Goodman*  
Licensed Embalmer No. *2424*  
P. O. Address *Holden m.*

**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.**