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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 8 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41572

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4965

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

1. PLACE OF DEATH:

(a) County Jackson County

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

(c) Name of hospital or institution: Little Sisters of the Poor
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 (Specify whether
In this community Twenty four days
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. 5331 HIGHLAND
(If rural, give location)

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

3. (a) PRINT FULL NAME Frank Hayes (Frank Hayes)

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex M.

5. Color or race White

6. (a) ~~Single, widowed~~, married, ~~divorced~~ Married

6. (b) Name of husband or wife Christine Clark

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

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: 68 Years | Months | Days | If less than one day ..... hr. ..... min.

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

10. Usual occupation None

11. Industry or business 1

FATHER
12. Name John Hayes 5
13. Birthplace Ireland 5 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ann Guthrie
15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant Sister Camille

(b) Address 5331 Highland Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-40 (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cem.

18. (a) Signature of funeral director Quirk & Tobin

(b) Address KCMo

19. (a) 12-29-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26th
year 4.15 hour ..... minute a M.

21. I hereby certify that I attended the deceased from Dec 18 1940, 1940, to Dec 26, 1940, that I last saw him alive on Dec 24, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	12 Hours
Due to Generalized Arteriosclerosis	several years
Due to [illegible]	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy no

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? (Specify type of place)

While at work? (e) Means of injury —

23. Signature John T Skinner (M. D. or other) MD

Address 1402 Bryant Bldg Date signed 12/27/40

(Licensed Embalmer's Statement on Reverse Side)

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 Maurice A. Lewis

Licensed Embalmer No. 3634

P. O. Address 20 W. Linwood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.