

FILED JUN 7 1943  
Registration District No. 149

Primary Registration District No. 1002

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:  
General Hospital No. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4-28-43-4-29-43  
(Specify whether  
In this community 57 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1620 Paseo  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME WESLEY HAYES

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

4. Sex Male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife Evelyn Hayes  
6. (c) Age of husband or wife if alive 49 years  
7. Birth date of deceased May 27 1894  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
58 11 2 ..hr. min.

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

10. Usual occupation none

11. Industry or business

MOTHER FATHER  
12. Name Don't know  
13. Birthplace Don't know  
14. Maiden name Don't know  
15. Birthplace Don't know

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 5-3-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Westlawn C.C.

18. (a) Signature of funeral director Thompson

(b) Address 1819 E. 75th St. No.

19. (a) 5-1-43 (b) M. M. Grom  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29  
year 1943 hour 3:45 minute a. M.

21. I hereby certify that I attended the deceased from  
April 28 1943 to April 29 1943  
that I last saw him alive on April 29 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Duration

Due to Hypertensive type heart disease with cardiac decompensation

Other conditions 93 D  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....

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?

While at work? (Specify type of place) (b) Means of injury

23. Signature J. Thomas (M. D. or other)  
Address St. Hwy #2-600 E 22 Date signed 4-30-43

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 *Spencer J. Flynn*

Licensed Embalmer No. 20211

P. O. Address 4819 E. 15<sup>th</sup> St. K.C.

**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, fact should be so stated above.