

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 3806

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH: Jackson
(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: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr 11 mo 12 da
In this community 62 years (Specify whether 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. 1400 Linwood
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. KATIE HAYDE

3. (b) If veteran, name war XX 3. (c) Social Security No. NO

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Stephen J. Hayde 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased No Record
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>Over 80</u>				hr. min.

9. Birthplace No Record (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Margt. McFarland

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

14. Maiden name No Record

15. Birthplace No Record (City, town, or county) (State or foreign country)

16. (a) Informant George Hayde

(b) Address 1002 Walnut

17. (a) Burial (b) Date thereof 9-4-43
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director J. W. Wagner
(b) Address Kansas City, Mo.

19. (a) 9-3-43 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2d
year 1943 hour 2: minute 33 A.M.

21. I hereby certify that I attended the deceased from Oct-15, 1941, to Sept 2, 1943
that I last saw her alive on Sept-1, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Encephalo-malacia
Myocardia
Due to Hypertension
Senescent Arteriosclerosis
Due to Coronary Sclerosis
Other conditions: Old Traumatic Left hip
Intelectual - Oct-1941
Major findings: _____
Of operations: _____
Of autopsy: 83c

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) _____
(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 Paul H. Brown (M. D. or other)
Address 106 W. 14th St. No. Date signed 9-3-43

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

106 22 14
RBE 0060

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. Hauschke
7159

Licensed Embalmer No.....

P. O. Address Kansas City, 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, fact should be so stated above.