S. No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 7 1944

Registration District No. 749

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 9829

Registrar's No. 1411

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: Lakeside Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks (Specify whether years, months or days)
In this community 21 yrs

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. 2001 E-33 St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3. (a) PRINT FULL NAME Fanny Melvina Haines
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Ambrose C. Haines
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased July 27 1865 (Month) (Day) (Year)

8. AGE: Years 78 Months 8 Days 1 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
FATHER
12. Name Ezeekiel Bailey
13. Birthplace No Record (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Eliza
15. Birthplace No Record (City, town, or country) (State or foreign country)
16. (a) Informant Frank C. Haines
(b) Address 2001 - E 33 St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-44 (Month) (Day) (Year)
(c) Place: burial or cremation Maple Hill, K.C.
18. (a) Signature of funeral director Mrs. C. L. Foster
(b) Address 918 Brooklyn
19. (a) 3-30-44 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28 year 1944 hour 1:35 minute P M.
21. I hereby certify that I attended the deceased from Feb 3, 1944, to Feb 28, 1944, that I last saw her alive on Feb 28, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 hr.
Due to Hypertension + Arteriosclerosis	
Due to	
Other conditions Chronic Nephritis (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 13/15

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 C. Blinn Rector (M. D. or other) D. O.
Address 1204 Prospect Date signed 8-29-44

(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.....

Licensed Embalmer No. 2570

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, fact should be so stated above.