V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5175

Registration District No. 149 | Primary Registration District No. 1002 | Registrar's No. 852

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

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: North East Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Days (Specify whether years, months or days)
In this community 15 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 112 So. Jackson 8
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Hattie May Hays
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Robert S. Hays
6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased Aug 7 1898 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
46	6	12	hr. min.

9. Birthplace Texas (City, town, or county) (State or foreign country)
10. Usual occupation Beauty Shoppe Operator
11. Industry or business Self
MOTHER
12. Name Baldwin
13. Birthplace Texas (City, town, or county) (State or foreign country)
FATHER
14. Maiden name Florence Nester
15. Birthplace Texas (City, town, or county) (State or foreign country)
16. (a) Informant Robert S. Hays
(b) Address 112 So Jackson
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-22-45 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cem
18. (a) Signature of funeral director Wm C L Foster
(b) Address 918 Brooklyn
19. (a) 2-21-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 19 year 1945 hour 5 minute a M.
21. I hereby certify that I attended the deceased from 12-11-44, 19..., to 2-19-, 1945, that I last saw her alive on 2-18-45, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Lungs	1 yr.
Due to Unknown	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Carcinoma of Lungs

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 Dr Thos E Day (M.D. or other) D.O.
Address 4316 E 9th K.C. Mo. Date signed 2-20-45

(Licensed Embalmer's Statement on Reverse Side)

Dr Day
Ch. 3474

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. A. Herrick

Licensed Embalmer No. 35-99

P. O. Address N C 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.